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J. J. Greenhof.

# TRANSACTIONS

OF THE

# Homœopathic Medical Society

OF THE

## STATE OF NEW YORK,

FOR THE YEAR 1901.

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**VOLUME XXXVI.**

EDITED BY THE SECRETARY,

DEWITT G. WILCOX, M. D.

BUFFALO, N. Y.

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"A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. *All that pertains to the great field of medical learning is his by tradition, by inheritance, by right.*"—*President Eugene H. Porter, M. D., Feb., 1898.*

Ordered published conspicuously in the Transactions every year.—Sept. 22, 1898.

*Rochester Democrat and Chronicle Print.*

*1901.*

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# PROCEEDINGS

OF THE

## Forty-Ninth Annual Meeting of the Homœopathic Medical Society of the State of New York, Albany, N. Y., February 12th and 13th, 1901.

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The forty-ninth annual session of the Homœopathic Medical Society of the State of New York convened February 12th, 1901.

DR. WILLIAM MORRIS BUTLER, President, showed his promptness by letting the gavel drop precisely at ten o'clock.

Prayer was offered by the REV. WILLIAM PRALL, of Albany, N. Y.

Secretary, DR. DEWITT G. WILCOX, Buffalo, N. Y.

*Committee on Attendance.*—Fred D. Lewis, M. C. Ashley, George F. Adams.

*Auditing Committee.*—Frank W. Adriance, R. K. Valentine.

*Committee on President's Address.*—F. Park Lewis, John L. Moffat, J. Willis Candee.

The Secretary presented the Transactions, as embodying the minutes of the Semi-Annual Meeting.

Drs. J. T. Cook, Asa S. Couch and R. A. Adams appointed as a special committee to draw up a memorial to the late Dr. A. R. Wright, of Buffalo.

President BUTLER made a very able and interesting address, the salient features of which were copied into the daily press, thereby resulting in much good to the Society.

### PRESIDENT'S ADDRESS.

*Ladies and Gentlemen*: I am privileged to address you to-day in accordance with annual custom.

We stand in the opened door of a new century. Our position grants us a double vista. In gazing hopefully into the future we must gauge our perspective of the untried decades by the achievements of the receding century.

It has become a trite saying that, while other arts and sciences have been yielding up their hidden treasures to patient toilers of the sea of ignorance, medicine alone crosses the threshold of the new century bearing empty nets.

Has medicine, indeed, but ragged right to the name of science? Is it called the healing art because it is artful? Let us look for a brief moment at the new quarterings on our profession's escutcheon. One hundred years ago to-day there were but three medical schools in these United States—Pennsylvania, Harvard and Dartmouth. The commissioner of education has recently sent to you and me a report, in which the present existence of 155 such schools is mentioned. Quantity only? is the natural query. Nay, quality and thoroughness as well. At that early date the curriculum provided for two years of study, which might easily be condensed into one. Four years are demanded at present, which with the subsequent regents' examination required, often lengthens into five.

In 1801 there were but two general hospitals in America, and there were but three medical journals published here. Now scarcely a town of a few thousand inhabitants fails to show its well-equipped hospital, while the number of medical journals has long ranged among the thousands. How has the lump been leavened? becomes a pertinent question. We find its answer in looking backward.

In gazing at the powerful current of progress which courses between the old century and the new, the eye quickly attaches itself to certain looming points in the stream, around which our thought, and the thought of centuries yet unborn, must eddy. We mention these jutting points, these grand discoveries together, hoping cursorily to consider them later. They are the science of bacteriology, aided by the establishment of laboratories, the discovery of anæsthesia, the discovery of antisepsis, the roentgen ray, the discovery of orrhotherapy, the discovery of various instruments of precision and the evolution of protective or preventive medicine.

In 130 A. D. Galen set the ball rolling, and down through the dim centuries it has gained impetus through names becoming famous from pole to pole.

When Edward Jenner inoculated his first patient 104 years ago, he built his theory on the proofs of Harvey. Our immortal Hahnemann was first awakened by translating the Materia Medica of the elder Cullen. Struck by the contradictory account given of the action of Peruvian bark, he worked out and established his theory that the healing of the afflicted must come through the study of the healthy organism.

In 1801, Bichat published in France his general anatomy, which was the natural outcome of his protracted study of the morbid anatomy of morgagni. The difficulties and expense attendant upon individual experimental observation called into existence a general socialism among students and investigators, and medical schools evolved the establishment of college hospitals, where theoretic instruction might receive instant clinical demonstration. Clinical possibilities impressed the need of laboratories for exact analysis. These laboratories at first were general, but they soon became special, so that every branch of instruction now has its individual plant where ologies are as scrupulously distinct as individual specimens.

And it is upon the certainties turned out by systematic and indefatigable laboratory work that medicine bases her claim to science. Until deposed by the authoritative voice of the microscope, the theory of spontaneous generation ruled the realm of medicine. Pasteur, Koch and others have proven incontestably to all the world the truth that spontaneous life is an impossibility, a fact dimly guessed at in the seventeenth century by the Jesuit Kircher. With the researches of Davaine and Pollender, the bacterial origin of disease became established. The universal acknowledgment of the germ theory of disease routed the antiquated tenets touching "humors of the blood."

The bleeding, blistering and cupping of the early part of the last century become little short of homicide, in the face of the undisputed fact, that normal blood possesses inherently, to a large degree, the germ destroying power. Any treatment, therefore, which diminishes natural resistance to disease, aids statistics of mortality. This bacterial origin of every variation from normal health, throughout the whole list, from lingering tuberculosis, small-pox, tetanus, all fevers and post-surgical ills, down to the briefest attack of grippe or influenza is now universally acknowledged.

From laboratory showings of differentiation between cocci, bacilli and spirilla have come indisputable diagnoses, the bacteria of different diseases presenting as marked individuality as human faces.

Perhaps all will concede that the most important surgical event of the last century has been the discovery of anæsthesia. Many of us indeed have gazed with interest on the very sponge, still preserved in the Massachusetts General Hospital, with which Morton administered the ether for Dr. John Warren's successfully painless operation in 1846. With equal success in the following year, eighteen hundred and forty-seven, Sir James Simpson employed chloroform in a capital operation in the city of Edinburgh. Since these dates many local anæsthetics have been variously employed with more or less of success. Of these latter cocaine undoubtedly remains the leader. Ether and chloroform, however, which transform into a complete hiatus those hours of crucial agony from which the bravest souls were wont to shrink, remain the favorites with surgeon and patient alike. The painless sleep is incontestably a "balm of hurt minds" and bodies too, and "knits up the ravell'd sleeve" of human life.

But the sequellæ of surgical operations in the way of blood-poisoning, erysipelas, gangrene, tetanus and pus-filled cavities under any and every name, often proved a lingering agony of death, in comparison with which the short, sharp shock of the surgeon's knife contracted itself to the merest cipher. Then came the grand discovery of Lord Lister. Antisepsis has become the twin-sister of anæsthesia, and the two enter together wherever the need of the surgeon's knife obtains. In this discovery are linked a high trinity of names: Jenner, Warren and Lord Lister. Their discovery of antisepsis comes from tireless laboratory labors. It received impetus from Liebig and Ogston, Davaine and Pasteur, and has

been greatly supplemented in the last fifteen years by Koch, Febleisen and Nicolaier.

In the last half decade of the century appeared the astounding discovery of the quickly-famous X rays; thus named by Prof. Roëntgen, of the University of Wurzburg, after the familiar mathematical emblem signifying the unknown quantity. Science is deeply absorbed in watching every development of the discovery of this modest professor, and is astounded by the phenomena presented.

Another outcome of laboratory work is the treatment known under the name of orrhotherapy, or serum-therapy. This introduces or injects under the skin a liquid antidote, or antitoxin, prepared from the blood of an animal which has passed through the same disorder, to overcome special existing toxins. This treatment has, thus far, shone most brilliantly in its application to diseases of the thyroid gland, and in cases of diphtheria.

The century has also shown astonishing progress in instruments of precision. Microscopy has become a developed science, and a knowledge of it is indispensable to every medical student.

I need only enumerate the ophthalmoscope, the rhinoscope, the otoscope, the hypodermic syringe, the aspirator, the clinical thermometer, the homostatic forceps, to recall to your minds the reinforced armamentarium with which surgeon and physician enter upon the work of the new century.

Largely from the study of bacteriology has sprung the respected ounce of prevention, which appears under the name of preventive medicine.

If present portents be not deceiving this field of teeming possibilities will command much absorbing thought in our prospective decades. Tireless laboratory workers will continue to enlighten us. If not radical enough to subscribe to Renan's boldly-flung suggestion that, with faultless hygiene man may come to live through indeterminate cycles, yet all intelligent men agree, that obedience to sanitary laws diminishes suffering and prolongs human life. Historian and archæologist assure us that principles of sanitation are a mere renaissance—a periodically reappearing comet on the horizon of sociology. We are aware that hygiene was a fad among the Egyptians, was a mosaic law, was a Greek inclination, was a Roman rule. But the disinterred baths of marble and porphyry served only the denizens of palaces. Our free swimming-baths to-day wash the populace. The modern hanging gardens of Babylon are the century's fresh air fund for the slums. Formerly, periodic visitations of small-pox, fevers and plagues devastated whole regions. We remember the scourges of the Roman Empire, and of the Orient, the great plague of London, and that two millions of people died of small-pox in a single year in the Russian Empire alone, prior to Jenner's efforts in preventive medicine.

These facts stirred the dormant altruism in the heart of Howard, and stimulated the inherent power of his brain. This awakened valetudinarian promptly laid the groundwork for differentiation among fevers. Louis soon distinguished typhus from typhoid, then

followed the minuter differentiations of the American Gerhard, Stillé and Shattuck. Graves and Stokes in Dublin, Jenner and Budd in England, Drake and Flint in America supplemented the earlier observations of French physicians, and thus by the seventh decade of the century the varied groups of fevers were distinctly tabulated.

This knowledge certainly means power, in looking toward the advancement of protective or preventive medicine. None the less, however, shall we need the eyes of an Argus and the hands of a Briareus in the contest before us. We read that public crime decreased ninety per cent. in London through the lighting of all her streets and alleys. It is not enough that physicians and students are enlightened on the prevention of disease. The flaring palace torch of the feudal ages, only served to make the darkness palpable. We must light up our human by-ways if we would decrease the per cent. of our scourges. The public must be educated as to the causative agents of diseases. The yet unfinished struggle against the contagion of tuberculosis illustrates the prevalent ignorance of avoidable dangers. Search out the origin of any scourge in any country, and its bacterial incubator is a slum.

But varied sanatoria and hygienic education of the masses will not reach all cases. It is not only against the Polish-Jew sweat-shop that the iron arm of the law must be raised.

"A fair mind in a fair body" was the aim of the beauty-loving Athenian. This will fail to satisfy the unborn child of the new two thousandth century. A *strong* mind in a *strong* body is now the ambitious goal of man and maid alike.

"*Similia similibus curantur*" is a law already proven to the adherents of our pathy, but in every pathy are the apostles of the truism of *Similia similibus productor*. The surest cure for an idiot is to leave him unborn. The same remedy is unfailing for a case of epilepsy. Already in the world, protective medicine must join hands with philanthropy and sweet charity, to free so far as possible, these poor unfortunates from incursions of mental, moral and physical bacteria.

But it is within the province of preventive medicine to try here the fabled "ounce." She must look to the bacteria—teeming marriage sweat-shop, if she will aid most efficiently in the production of a strong mind in a strong body. The long generations of sick criminals authentically traced by the indefatigable Dugdale to the single epileptic criminal, Belle Juke, is the familiar and efficient argument employed in invoking aid for restricted marriage laws. Attested facts have been furnished by Darwin and Ribot, Dugdale and Maudsley, Lombroso and Ferrero, and a host of discoverers, investigators and tabulators. With the bacillus of crime affixed to the slide, no powerful microscope is needed to describe its eccentricities, or its possible port of entry into its victim. It is born into the fœtus. The idiot, the insane, the epileptic cannot even protect himself from the attack of the insidious physical cocci, bacilli or spirilla.

Through adherence to the fine old sentiment "Noblesse oblige," the philanthropic heart of a Pinel or an Esquirol, and the application of modern ideas of sanitary law, we may do our best for him

under the circumstances, in public hospitals, asylums and homes, under trained nurses that are educated, efficient and conscientious. But after all, do we not owe it to him and to the cause of human progress, that his "degenerate days shall die"?

The irrevocable law of heredity needs no attempted support from my puerile pen. This law is attested history, and prior to that was accepted legend. The deformity of Vulcan was popularly ascribed to the drunken rage of Jupiter at the time of his conception.

Herodotus, writing five centuries before Christ, in detailing the murders and incest of the Persian King Cambyses, gives inherited epilepsy as the impelling cause. Ribot's tables of ancient dynasties are familiar to us all. Our old friend, Burton, in his anatomy of melancholy, which has instructed and amused us all, writes in 1652: "It is the chiefest human felicity to be well-born, and it were indeed happy for human kind, if only such parents as are sound of body and of mind should be suffered to marry and to beget children."

In number xii of the Forum, W. F. Spaulding writes: "Crime can no more be reduced by punishing the criminal than recurrence of small-pox epidemics were stopped before Jenner's day by the possible cure of an isolated victim. The criminal is a product. Stop the product if you would decrease crime." In ancient Scotland a measure existed for the repression of undesirable parentage. The cause of its enactment was explained as making for national weal, "lest in process of time the whole race become infected, corrupt, and rotten to the core."

A single citation may serve to show that this fear might indeed prove itself well-founded by the precedence of fact.

In a French work recently issued (*Un pays de criminel-nés*) the author alludes to a district in Italy which is remarkable for the historical continuity of its intense criminality. He describes it as perched upon a hill, with a magnificent view of the fields spreading toward the mountains of Latium. It appears to the stranger a land of delights, where the inhabitants must be gentle and peaceful as the sweet smile of nature by which they are encompassed. The soil is fruitful, the occupations chiefly agricultural. Nevertheless, for ten centuries the people have made themselves famous in history as incestuous, thieves, brigands, assassins, with an astonishing per cent. of idiots and epileptics.

Pope Paul IV. proclaimed an edict of banishment against the whole race, and authority to kill them was granted. Yet these negative measures have never extirpated this nest of evil, and fair Artena is known to-day as Artena, the foul, the ferocious, the barbarous.

Although since the fabled days of Jove man's faith in heredity has never faltered, it remains for the men of earnest, scientific thought to enact in the twentieth century what may be termed sanitary marriage laws in pursuance of the desire to decrease suffering, and to elevate the human race. This is indeed an obvious phase of preventive medicine. The public is gradually awaking to the desirability of choosing its own father, to the disastrous influence of epileptics

and of the feeble-minded as parents and it has initially initiated the ancient Scot in seeking relief through legislation.

A law was recently passed in the State of Connecticut with the following text: "No man or woman, either of whom is epileptic, imbecile or feeble-minded, shall inter-marry or live together as husband and wife, when the woman is under forty-five years of age." (This is quoted from Hunt's article in the Northwestern Lancet, XVII., 3.)

Last month, January, 1901, Dr. Clinton introduced a bill into the Legislature of the State of Minnesota, which provides that marriage or co-habitation shall be prohibited between a man and a woman, where either is, or has been, insane, epileptic, or feeble-minded, and that the certificate of a physician avouching the fitness of the applicants to enter the married state, shall accompany each and every application for marriage license. This act places the age limit for women at forty-five years, but makes no provision for the age of men. The penalty for a violation of the law is $1,000, or five years in the penitentiary, and applies not only to those who marry, but also to the clergyman or justice performing such illegal ceremony.

It is claimed that mid-ocean and high altitudes (like Alpine peaks) are the only resorts of human race where nature has not scattered her death-dealing bacteria. It would seem that a half dozen decades of the high altitude to which Minnesota's social relations aspire, must certainly purge that state of such protoplasmic life as has lent foul fame to fair Artena.

HOMŒOPATHY.

One hundred years ago to-night our pathy was a derided Ishmaelite. To-day its claim upon public attention has assumed the proportions of a race of healers, rather than a mere inconsequential tribe. Nowhere is our power more thoroughly recognized than in the camp of our intelligent opponents. Under the banner of Hahnemann we have already won in many a valiant fight, but equal legal recognition is still begrudged or denied us.

Within our own ranks much should be expected from the new century, in the improvement of our Materia Medica. In previous efforts at expansion we have placed little check on the vagaries of the imagination, and a misleading garrulity has sometimes resulted. The effort of the future should look with judicial eye, and scientific accuracy toward elimination, condensation and exactness.

Convinced and convincing, as we are, that our therapeutic faith is founded on a rock, it is to be hoped that careful, discriminating workers will anticipate in its behalf a lagging natural evolution.

*Ladies and Gentlemen:* In laying down the office with which it was your pleasure to honor me at your last election I desire to thank you for the intelligent and cordial support which, as your President, I have received at your hands during the last year.

Our meetings have been well attended. The chairmen of the various bureaus, faithful to their promises, have in each instance furnished us with interesting and instructive papers. The chairmen of committees

and sub-committees have worked in perfect concord, which fact has been productive of comfort and pleasure to not only ourselves, but which at our successful Jubilee meeting redounded in honor to all adherents of homœopathy. For this, gentlemen, in the role of your chosen official, it is my valued privilege to thank you.

In vacating this coveted and honorable office, I desire to bespeak for my successor the same ready courtesy, efficient co-operation and fidelity to the steadily advancing cause of Hahnemann that has been conspicuous in the attitude of this body toward myself.

## REPORT OF THE COMMITTEE ON PRESIDENT'S ADDRESS.

The Committee on President's Address reports as follows:

Your Committee beg leave to report that they have listened with pleasure to the comprehensive and scholarly address of the President of this Society and that they fully concur in the views therein expressed. They congratulate the Society on the broad and advanced position that he has taken and they trust that in the not distant future, the community may be prepared to entertain and act upon his wise and judicious suggestions.

F. PARK LEWIS,
JOHN L. MOFFAT,
JAS. WILLIS CANDEE.

## REPORT OF THE COMMITTEE ON ATTENDANCE.

Although somewhat disappointing to find no larger number were in attendance at this meeting, yet the general interest and enthusiasm manifested made up to a very great degree the absence of members. The Committee enrolled the following fifty-six:

*Albany County*—F. J. Cox, E. T. Schwilk, J. Ivimey Dowling, G. J. Gannett, Edward G. Cox, George A. Cox, William J. McKown, George E. Gorham, H. D. Cochrane, S. H. Carroll.—11.

*Broome County*—L. A. Martin.—1.

*Cayuga County*—Charles A. Gwynn.—1.

*Chemung County*—F. W. Adriance.—1.

*Erie County*—DeWitt G. Wilcox, Joseph T. Cook, F. Park Lewis, Frank B. Seitz, Fred D. Lewis, George F. Adams.—6.

*Dutchess County*—A. L. Peckham.—1.

*Fulton County*—W. S. Garnsey.—1.

*Kings County*—R. K. Valentine, John L. Moffat, William M. L. Fiske, W. B. Winchell, William Morris Butler.—5.

*Monroe County*—R. A. Adams, Newton M. Collins, J. M. Lee.—3.

*Montgomery County*—L. A. Frazier.—1.

*New York County*—Wilfred G. Fralick, George W. McDowell, George W. Roberts, E. H. Porter, Walter Sands Mills, Sidney F. Wilcox, Thomas Franklin Smith, A. Worrall Palmer.—9.

*Oneida County*—M. O. Terry, C. T. Haines, C. Gray Capron, A. R. Grant.—4.

*Onondaga County*—J. Willis Candee, W. L. Hartman.—2.

*Orange County*—M. C. Ashley.—1.

*Schenectady County*—W. D. Spoor, H. L. Towns, Wm. P. Faust.—3.

*Steuben County*—E. W. Bryan.—1.

*Sullivan County*—Howard P. Deady.—1.

*Tioga County*—J. T. Greenleaf.—1.

*Tompkins County*—Martin Besemer.—1.

*Washington County*—D. E. Spoor.—1.

*Wyoming County*—W. B. Gifford.—1.

## REPORT OF THE BOARD OF CENSORS

recommended the following seven, all of whom were elected to permanent membership:

| | ENDORSERS. |
|---|---|
| HARRY HERBERT CRUM, Ithaca, *VIII, 1900, | Martin Besemer, D. G. Wilcox. |
| A. R. GRANT, Utica, VII, '97, | C. T. Haines, M. O. Terry. |
| ALFRED DRURY, A. M., New York, I, 1900, | M. C. Ashley, S. F. Wilcox. |
| GEORGE READ CRITCHLOW, Buffalo, III, '98, | F. Park Lewis, Joseph T. Cook. |
| THOMAS F. DAVIES, New York, I, '98, | J. B. Garrison, G. W. Roberts. |
| J. HUBLEY SCHALL, Brooklyn, III, '93, | T. H. Smith, J. L. Moffat. |
| ARTHUR A. VIBBARD, Sloansville, I, '94, | J. B. Garrison, G. W. Roberts. |

## TREASURER'S REPORT.

Dr. Deady, Treasurer, made his report, which was reported correct by the Auditing Committee appointed for that purpose.

Charles Deady, M. D., Treasurer, in account with Homœopathic Medical Society of the State of New York.

| | | |
|---|---|---|
| Dr. | | |
| To Balance on hand February 13th, 1900 | $ 732.71 | |
| To Cash received from members and County Societies | 1,384.00 | |
| Total Cash received | | $2,116.71 |
| Cr. | | |
| By Cash paid out as per vouchers | $1,552.82 | |
| By Cash on hand to balance February 12th, 1901 | 563.89 | |
| | | $2,116.71 |

The Society is under obligations to Dr. Deady for his long and excellent services as Treasurer, the same being satisfactory in every respect.

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* I. New York Homœopathic Medical College and Hospital.
II. New York Medical College and Hospital for Women.
III. Hahnemann of Philadelphia.
IV. Hahnemann of Chicago.
V. Chicago Homœopathic Medical College.
VI. College of Physicians and Surgeons, New York.
VII. University of the City of New York,—Medical Department.
VIII. Cleveland Homœopathic Medical College.

Dr. Deady made the following remarks after presenting his report:

"I would say this is really a higher balance than usual. The difference is made up by the fact that the Society appropriated $250.00 to the Hahnemann monument fund and $75.00 for expenses in bringing out-of-town physicians to the Brooklyn meeting; otherwise the balance would be $50.00 higher than last year."

## COMMITTEE ON NECROLOGY

reported the deaths of A. R. Wright, Clarence E. Beebe, F. W. Spoor, Wm. T. Laird, Harriet Barkeloo. (See Appendix.)

The following remarks were made by Dr. Garnsey, Necrologist, before presenting his report:

"I have no paper to present, but I wish to make a few remarks to the effect that not only situated as I am, in a small interior town, being dependent largely upon the membership of the Society for notices regarding the death of members, I very frequently fail to hear of the death of some of our members until quite a long period of time has elapsed. Our Secretary has sent me notices and Dr. Wilcox has also sent me notice of a man, but the member had been dropped for non-payment of dues. If the membership would send me notice immediately of any death which has occurred within their immediate circle, so that I could look up the information regarding them, I would be able to present papers much more promptly and frequently than I do. Since coming into the house to-day I have received some data which will help me to write up a notice of one that died more than two years ago, which information I tried to obtain eighteen months ago. It is quite a slow process to try to obtain any information. I have no paper to present to you."

## JUBILEE COMMITTEE

reported as follows:

"As to a report from the Jubilee Committee I can only say that the Committee has done its work and that the results were before the Society last October. The Committee feels extremely grateful to the distinguished physicians who came from a distance to address us and to all others who contributed to the success of this meeting. The one regret is that in spite of all the effort made to secure a large attendance, the number of those present was far from what it should have been.

ALTON G. WARNER, *Chairman Jub. Com.*

## REPORT OF THE COMMITTEE ON LIFE INSURANCE COMPANIES.

Your Committee on Life Insurance, appointed at the last annual meeting, for the ensuing year, has carefully observed the attitude of the different old line insurance companies to our particular school of medicine. The Committee begs to report that these companies, as a rule, are manifesting a friendly attitude towards us. Especially is this

true in New York City, where, as we are made to understand, these companies are more lenient in regard to homœopathic examiners than formerly. Several appointments in different places throughout the State have come to our notice. Among them, Dr. S. R. Snow, of Rochester, has received an appointment as examiner for the New York Life Insurance Co., and Dr. J. D. Zwetsch, of Gowanda, as examiner for the Equitable Life Insurance Co., of New York City. If our observation is correct, the prejudice in many medical departments is gradually disappearing, and medical directors are finding out that homœopathic physicians are as well educated, and as well qualified to make careful examinations for life insurance, as old school physicians; and if those who are already appointed will only do good work it will materially improve the attitude of these companies towards us. I regret my inability to be present at the meeting.

Respectfully submitted,

EDWIN H. WOLCOTT, *Chairman.*

## REPORT OF THE COMMITTEE ON MEDICAL LEGISLATION.

There are a number of bills before the Legislature that require immediate consideration.

1. The so-called Bell bill. In Assembly No. 167, the amended bill will have new number. This bill is designed to compel every person who treats disease to comply with the medical laws of this State. Medical laws are necessary for the proper protection of the community and they should include everybody who treats disease as a business. It is one thing to say that a citizen should have the right to be treated by a certain system or lack of system, and it is quite another thing to say that any one may treat disease without a proper medical training and education.

2. The Seymour bill. Senate 538. Assembly 759. This is the "Osteopath" bill. It will give to people who have not been educated as physicians the right to treat any and all diseases by the method known as osteopathy. If they gain this privilege it cannot be expected that other practitioners will comply with the requirements of medical colleges when they can obtain the same standing in the community by attending some osteopathic college. It is a most vicious bill and must be defeated. Write at once a strong letter to your senators and assemblymen urging its defeat.

3. The Adler bill. This bill compels the Regents to endorse the diploma of any physician who has passed the State Board of Medical Examiners in any other State. If this applied only to states where the requirements were similar, although inferior to our own it would be bad enough; but it goes further and applies to all states. Should this bill become a law students can then go to some states where the requirements are almost nothing and having received the right to practice there, come to New York and practice here. This is a direct discrimination against the medical colleges of this State and will make a farce of our medical laws.

The Bell bill should receive our earnest and active support and *at once.* The second and third bills named in this letter should be

actively opposed. See your representatives and have others see them; write strong letters and get as many others to write as possible.

E. H. PORTER, *Chairman.*

## REPORT OF THE COMMITTEE ON STATE MEDICAL EXAMINERS.

*To the Homœopathic Medical Society of the State of New York:*

The State Board of Medical Examiners representing this Society would respectfully report as follows:

In the academic year, August 1, 1899, to July 31, 1900, there were four examinations for medical license at which 792 candidates appeared as follows: Old school board, 710; Homœopathic board, 58; Eclectic board, 24. Rejections were,—of Old school candidates, 132 or 18.59%; Homœopathic candidates, 5 or 8.6%; Eclectic candidates, 6 or 25%.

In all, 5,600 candidates for State medical license have been examined, rejections being 1,229 or 21.9%. During the year 107 physicians have been licensed by the regents under exemptions as provided in the medical laws.

The superior qualifications for this test possessed by New York State graduates is shown in Secretary Parsons' annual report for 1900, they averaging one rejected answer paper to four candidates, while graduates from outside American colleges failed in more than one paper and foreign graduates in more than two papers per candidate.

February 12th being a legal holiday, the annual meeting of the board was called by the regents for the 13th inst. at 10 a. m., hence its proceedings cannot be incorporated in this report.

Since our last meeting, the *personnel* of the board has undergone decided change. In the death of Dr. A. R. Wright, who had served continuously since the licensing law became operative, was lost a man whose character and attainments commanded the love and admiration of his colleagues—one whose conscientious work denoted a public servant in whose keeping the interests both of profession and laity were always safe. We mourn the good Dr. Wright. Ill health, compelling removal from the State, has also taken from the board, Dr. F. F. Laird. It is greatly to be regretted that we are thus deprived of the services of one who in scholarly equipment and professional ability is singularly fitted for work of this character.

As successor to the late Dr. Wright, Dr. Edward Chapin, of Brooklyn, has served acceptably. Dr. W. N. Bell, of Ogdensburg, has recently been appointed to succeed Dr. Laird. The assignment of duties has also been changed, Dr. Bell taking the department of anatomy and Dr. Candee that of obstetrics.

A special topic for consideration at to-morrow's meeting will be the question of reciprocity between the various States.

ASA S. COUCH, *President.*

JAS. WILLIS CANDEE, *Secretary.*

February 12, 1901.

## REPORT OF THE COMMITTEE ON INCREASING MEMBERSHIP.

DR. F. PARK LEWIS: "The Chairman has no written report. The members individually have been endeavoring to increase the membership of the Society. Circulars have been sent around to those not members and individuals in different sections of the country. Special members have been delegated personally to solicit membership and it has been efficiently carried on during the last year."

## REPORT OF COMMITTEE FOR INCREASING THE INTEREST IN MATERIA MEDICA.

*Mr. President and Members of the New York State Homœopathic Medical Society:*

Your committee would respectfully recommend that this Society consider the wisdom of coöperating with the American Homœopathic Ophthalmological, Otological and Laryngological Society in a plan approved by that body for the re-proving of drugs, a definite scheme having been formulated for the advancement of this work under the supervision of specialists. In the opinion of your committee, interest in the homœopathic materia medica can best be aroused and fostered by engagement in active work in that department, of such nature that it may commend itself as being desirable and practical. The above mentioned undertaking would seem to suit these conditions and insure what, in respect of the subject in question, is both indispensable and difficult of attainment—*activity.*

We believe that this important work should not be limited to a specialty or to any number of them, but that it should be jointly conducted by and in the interests of all specialists and general practitioners as well, hence the suggestion to coöperate in the most commendable departure of the O. O. & L. Society which, it is hoped, may prove to be the signal for a general advance by our profession.

We also feel that the work should ultimately include new provings, urgent need of which is recognized by all.

The methods approved by the O. O. & L. Society commend themselves to your committee, and we would respectfully suggest the same as a basis of arrangements for the alliance of this Society.

We desire to submit copy of a letter from Dr. H. P. Bellows, of Boston, Mass., who is the director in behalf of his society; also extracts from Dr. Bellows's presidential address bearing upon this subject:

Boston, Mass., February 8, 1901.

J. W. SHELDON, M. D.,

*Dear Doctor:* I have received your letter of the 6th inst. in regard to the matter of re-proving which is engaging the attention of our O. O. & L. Society and am greatly pleased at the interest which you manifest in the project.

I send you by this mail a copy of the address which contains the outline of the plan proposed, marking such paragraphs as you will find bearing most directly upon the subject. It was voted by our

society that the President select a single standard pharmaceutical preparation for such proving; that he appoint committees composed of representative men from our large cities to carry on this work, and that a report of the work accomplished be made at our meeting next year. In accordance with this vote, I have selected the remedy to be put to the test and have appointed committees from the membership of our society in thirteen of the largest cities, New York, Brooklyn, Chicago, Philadelphia, St. Louis, Boston, Baltimore, Cincinnati, Buffalo, Cleveland, Detroit, Washington and San Francisco.

You will notice that, in your particular State, these committees are chosen consisting in New York of Drs. Garrison, Deady and Townsend; in Brooklyn of Drs. Moffat, Schenck and A. G. Warner; in Buffalo of Drs. F. Park Lewis and F. B. Seitz. In each case, the first mentioned is, of course, the chairman.

I am now waiting for more definite instructions from the Executive Committee of our O. O. & L. Society in regard to the next step to be taken, but it will doubtless involve the invitation of a similar number of their colleagues in each of these cities to join with them in the formation of a band of provers to put this selected remedy to the test in accordance with the plan outlined in the reprint I mail, and approved by our society. The part which your society would help immensely by taking would be to approve of making the test proving prepared; to encourage such of your members as may be selected by our committee and invited to coöperate with them to do so, and to lend a hand in raising the necessary funds.

Just how much will be required no one living knows as yet, but the more raised, the greater the number of persons which can be hired and the more thorough the work accomplished. I should say it would be the simplest way to vote a certain definite sum from the treasury or to be raised by special assessment possibly and guaranteed by the society, which can be equally divided among the proving bands actually organized in your State, one, two or three, and let each band make it go as far as possible, and add to it any further sums which they may be able to obtain from other sources as well.

This is, of course, nothing but a suggestion on my part, but if carried out it would be of the greatest benefit to our society, not only in the actual financial aid given but as forming a precedent which the State societies might follow when the leadership of your New York society is seen. I feel somewhat delicate in making even a suggestion of this nature to the chairman of a society to which I have not the honor of belonging, but at least it is practical and definite, and that I presume is what you desire.

In regard to my visiting Albany, and attending the meeting of the Society, it will be entirely impossible for me to do so, on account of my engagements for next week and the generally increased pressure of my daily work just at this time. It would afford me very great pleasure could I be present. Kindly write me your address in Albany so that I may acquaint you with the latest phase of this movement in case anything transpires between now and the time of your meeting.

H. P. BELLOWS.

Following are extracts from Dr. Bellows's Presidential address referred to and containing the plan in question:

It would seem, then, that, as a modern, scientific method of drug proving demands that the individual provers be subjected to judicious questioning in regard to the symptoms which they record and to adequate tests to determine their physical and functional states; and as the majority of such examinations can best be made, and some of them can only be made by physicians of special training, the work of conducting drug provings in future should largely rest in the hands of organized bodies of specialists. On the other hand, it is obvious that the general supervision and direction of such provings should be vested in the hands of either a general practitioner of the largest possible experience, or in those of some specialist whose knowledge of the spirit and methods of specialists is supplemented by a large and broad previous experience in the general practice of medicine. This is absolutely essential in order that each proving should proceed from the broadest generalization to the closest study of particulars—the general systemic action of the drug never being lost sight of in its particular effects upon individual organs. Only one with wide personal experience in general medicine, and with a large and comprehensive grasp of materia medica in its generalities and broad characteristics, can properly assume the direction of a scientific drug proving; but the corps of trained specialists and laboratory experts for blood, urinary and possibly bacteriological examinations and physiological tests are also indispensable to the most complete results.

* * * * * * * * * * *

It is evident that, to obtain provers in the future, they must be sought out, and when found must be offered some substantial inducement to enlist their interest and to secure their full coöperation in the work which they undertake. In other words, it is my belief that, with few exceptions, the provers of the future must be paid. The exceptions will be the few men here and there who are possessed of sufficient leisure and are enthusiasts in medical science.

* * * * * * * * * * *

And when, as we look back at our individual experiences, did the earning of a few dollars seem more desirable or necessary? It is my belief that our very provers in the future will be recent graduates of medicine, resident in our large cities and closely in touch with our college and hospital laboratories. This introduces another subject for consideration and that is the relation of the city physician and the country physician to this work of re-proving our materia medica.

Since the examination of provers and the verifying and recording of their symptoms must rest largely in the hands of an organized body of specialists, and these examiners must be able to avail themselves to the fullest extent of laboratory tests, it follows of necessity that the provings must be conducted in our cities or in close association with our medical colleges where alone such bodies of specialists and such laboratory facilities are to be found. But while the burden

of the actual work of proving must rest upon city physicians there is no reason why country physicians should not bear their share of the expense which such proving entails. In fact, this is about the only way in which the country physician can participate in this work, the benefits of which are shared in exactly equal degree with the city physician. There are few physicians in the country who are not both alumni of one of our medical colleges and members of one of our State societies.

Unless funds can be raised for the specific purpose of drug proving by the contributions or bequests of wealthy individuals, either physicians or laymen, the most natural sources from which such appropriations could be derived would be the working funds of our medical colleges or the treasuries of our State societies. In the former case the concerted effort of the alumni could be most fittingly directed to the raising of the extra funds required, the results obtained from the expenditure of which would so closely touch the honor, the reputation and usefulness of their alma mater, as well as to directly accrue to their individual benefit. In the latter case, should the expense of re-proving be borne by our State societies, the increased demand upon the treasury could be provided for by temporarily augmented annual dues, the country physician in this event bearing his full share of the assessment.

* * * * * * * * * * *

Is it not better to look for the necessary funds to private sources or to the faculties of our medical colleges who may disburse sums specially raised and intrusted to them for this purpose, or to the treasuries of our State societies, replenished by the assessment of special dues? It need hardly be said that the items of expense would be the payment of some adequate compensation to the men and women who act as provers, and possibly to the laboratory assistants, together with the expense of laboratory material, and probably nothing more. It is scarcely to be doubted that the physicians and specialists who examine the provers and conduct the provings will give their time and services without thought of other compensation than that which comes from the satisfaction of advancing so worthy a branch of medical science.

* * * * * * * * * * *

To summarize, in closing, I should say, therefore, that, from the standpoint of a specialist, the re-proving of the homœopathic materia medica requires that such work be done either in our large cities or in close connection with our medical colleges; that it be conducted by organized clubs or boards of physicians which shall be presided over by a master or director of provings; that this director shall himself be a general practitioner of the largest possible experience and the broadest knowledge and grasp of materia medica, or that he be a specialist who has previously had such general experience in medicine; that he shall have associated with him two or three other general practitioners for the division of labor and a body of specialists for the examination of special conditions and the testing of special organs,

and that these shall cover the mind and nervous system, the eye, the ear, the nose and throat, the chest, the genito-urinary system and the skin; that arrangements shall be made for the assistance at all times of laboratory experts for chemical, microscopical, bacteriological and physiological tests; that the provers shall receive some adequate compensation for their time and services, the means to come from private sources, from funds administered by our medical colleges, or from the treasuries of our State societies; that the provers shall be subjected to careful preliminary organic and functional tests; that they shall receive the drug to be proven at the hands of the director of the proving so guarded by blanks and counter-tests that they shall not know the nature of the drug taken or when the actual administration begins; that the examiners themselves shall not know what drug is being proven or when it is being administered, but may receive special hints or practical suggestions from the director at his discretion; that the prover shall keep a daily record of his own condition and symptoms in a book provided for this purpose and shall submit this written record every day to the director of the proving; that, after careful questioning, the director shall each day send the prover to such specialists as may seem desirable for the further testing and verification of special symptoms or conditions which may arise, the visit to be made during the specialist's office hours or at such other convenient seasons as may be specified in advance or arranged at the time by telephone; and that, finally, the results of the proving, as a whole, shall be summarized and arranged for publication in scientific form by the director with such aid from any or all of his associates as he may desire.

Respectfully submitted,

J. W. SHELDON, *Chairman.*

DR. MOFFAT: Dr. Schenck's report was in line with this very subject. Then there were a few sentences from the presidential address, which will give the gist of the idea. President Bellow instanced the case of a patient coming to him for a peculiar grating and rustling noise in the ear. He looked up his Materia Medica and found a remedy that had caused (?) such rustling in the ear. Before giving a high potency, he looked into the ear and discovered a little short hair held by the wax and impinging on the drumhead, which it rubbed upon certain movements. The time has come for the interpretation and critical scanning of the symptoms of our provings, that is, scientific, critical re-proving. What does "dim vision" signify? It may be due to any one of several radically different pathological conditions. If we are content to rely upon subjective symptoms alone, we are fifty years behind the times. It would be a waste of effort and money to conduct a proving upon only the eye, ear, nose and throat. The Am. Hom. O. O. & L. Society wishes your coöperation, that of the institute and of the whole profession. Paid provers should be guided, criticised, examined and their symptoms checked by experts in materia medica, general practice, gynæcology, diseases of the chest, bacteriology, examination of the urine and of the sputum.

## MISCELLANEOUS BUSINESS.

By motion of Dr. Moffat and action of the Society, a standing resolution was made by which the Treasurer should hereafter present to the Society, in his annual report, a detailed statement of the expenditures of the Society, not merely giving the bulk expenditures alone.

Dr. F. Park Lewis offered the following resolution, which was adopted by the Society:

WHEREAS, It has been contemplated to reduce the appropriation for wages in institutions for the care of the insane in this State, involving a consequent reduction in all the force of employees, nurses and attendants employed in the several State Hospitals, therefore, be it

*Resolved*, That the State Homœopathic Society hereby expresses its conviction that it should not be the policy of the State to lower the present standard of care of these dependent wards of the State, or, by such lessened appropriation, diminish the number of those employed in their care, and the Legislature is respectfully requested to take no action looking to this end.

DR. F. PARK LEWIS: Personally, I know that the most efficient work is being done with an exceedingly limited staff in the Gowanda State Hospital. I do not know anything of the Middletown Hospital, but I feel that it would not only be hurtful to the best interests of the Gowanda State Hospital to have the staff further reduced, but there should be an added force to have the work done as well as it can be done. I do not believe the Governor can be fully informed as to the necessities of the case in regard to certain hospitals, at least, when he makes this suggestion. I feel that this resolution is very timely and I hope it will obtain.

DR. BUTLER: It is poor economy to reduce the employees in any State institution by hiring cheaper help. The Middletown employees in the past have been of high character. Dr. Ashley last night spoke about one of the nurses who received fifteen dollars a month. She has been in my employ for the past two years and I have kept her constantly at work at $25.00 a week. There will be a great many of their good nurses taken out of Middletown if they cannot give at least fifteen dollars a month. This nurse was just as good in Middletown at fifteen dollars a month as she was working for me at $25.00 per week. We do not want these patients treated as those were in one of our city institutions. The example at Bellevue should be a warning to the Governor. The grand jury, I think, now have three of their nurses under indictment. We do not want our Middletown Asylum or Gowanda Hospital to have any employees of that character.

DR. MOFFAT: I think we will all sympathize with the Governor's aim, economy, so far as he does no harm by parsimony. It is impossible to get good work from underpaid nurses. There are plenty

of other ways in which the State can economize without cutting down the present small pay of these attendants. I think it would be economy to increase their pay rather than to diminish it.

DR. ASHLEY: I might add that we have about reached rock bottom prices in the payment of our nurses and other help to care for the insane. Some two years ago, a large reduction was made, not only in our force, but in the wages and a year ago we were required to dispense with one member of the medical staff. If we keep reducing our force we must eventually return to the old county pauper system of caring for the insane. We were at one time in pretty good shape at Middletown. We were permitted to admit a great many private patients and use the proceeds of those patients to make them comfortable and the hospital homelike. That income has been denied us and we are getting back to the county house system. If there is still a further reduction in the wages and the number of our employees, the standard of care must be proportionately lowered.

DR. N. H. HAVILAND, of Fulton, and DR. E. HASBROUCK, of Brooklyn, were elected Senior Members.

The following resignations were presented by the Secretary: Drs. H. N. F. Cooke, New York; Mary M. Hoyt, Rochester; A. H. Bruce, Wolcott; and Eloise I. Church, New York.

The following resolution of Dr. Moffat's was unanimously adopted:

That the Bureau of Materia Medica be instructed to coöperate with the American Homœopathic O. O. & L. Society in re-proving our materia medica, bending their energy primarily to that end; and that this Society appropriate two hundred dollars during the coming year to defray the expenses incurred in such re-proving.

DR. MOFFAT: Our Materia Medica Bureau would seem to be the proper machinery for this. Part of it, at least, can be appointed for this especial work, while the rest (with the Chairman) see that the ordinary business of that bureau is not neglected. As to the appropriation of $200.00, this Society can have no more legitimate call upon its treasury than for this advancement of the cause of Hahnemann. We can afford to give $200.00. Last year we gave $250.00 to the Hahnemann statue and $75.00 more to the Jubilee Committee —$325.00. This, of course, is only the beginning. The work will require years for its completion.

DR. R. A. ADAMS: I want to second this resolution. This seems like a Rip Van Winkle awakening. I want to contribute $50.00 as a supplement to the appropriation from this Society furthering the cause.

DR. BUTLER: It seems to me it is an exceedingly worthy object. There are so many foolish symptoms in our materia medica; so many provers have gone into it that did not know what they were doing. A man was proving calcarea carbonica, felt cold after taking a cold bath (laughter).

Dr. F. Park Lewis offered the following resolution relative to the Fancher bill, which was unanimously adopted:

WHEREAS, It is recognized by veterinarians generally that tuberculosis is an exceedingly prevalent disease in domestic cattle, and

WHEREAS, It is also recognized that it may be communicated by means of infected milk, and,

WHEREAS, Milk is an almost universal food with people of all ages and especially with children, and

WHEREAS, There is as yet no adequate inspection of the herds furnishing the milk supply for our cities and villages. Therefore be it

*Resolved*, That we endorse the bill now before the Assembly, entitled, "An Act to Amend the Agricultural law relative to diseases of domestic animals; to repeal article four of the public health law and incorporate in its stead certain provisions of the agricultural law relating to public health, and making an appropriation to carry out the provisions of this act."

*Resolved*, That a committee be appointed to confer with Mr. Fancher and to urge that a sufficient appropriation be added to the bill to make effective such examinations and tests, both at the border and within the State as will give efficient protection to the people from tubercular infection from this source.

The following committee was appointed to carry out the suggestions contained in the resolution of Dr. F. Park Lewis relative to the Fancher bill: Dr. F. Park Lewis, Buffalo; Dr. J. W. LeSeur, Batavia; Dr. George E. Gorham, Albany.

In the absence of Dr. Cook, as Chairman, Dr. R. A. Adams reported as follows concerning the death of Dr. A. R. Wright.

Your Committee deem it a great honor, as well as a sad duty to be called upon to prepare this brief memorial of our beloved fellow member and friend, Dr. A. R. Wright, of Buffalo, who passed from our midst during the year.

Dr. Wright had been a familiar figure at all of our gatherings, and we, one and all, shall miss his genial presence and active work.

He had been for some years a senior in this Society, as well as a senior and ex-president in the American Institute of Homœopathy and we gladly make this public acknowledgment of our appreciation of his exceptional and self-sacrificing devotion to the interests of this Society and of its individual members.

In Buffalo, where he practiced for nearly half a century, he had been a pioneer and always a leader in the development and progress of homœopathy, and in the establishment of the local hospital, which he served most faithfully up to the day of his death.

We keenly realize how great a loss this Society has sustained in his removal.

An extended report of his life and works will be found in the Necrologist's report for the current year.

We suggest that his portrait be published in the next issue of the Transactions, and that a copy of this memorial be sent to his family.

JOSEPH T. COOK,
R. A. ADAMS,
ASA STONE COUCH.

The election resulted as follows:

President—J. T. GREENLEAF, of Owego.
First Vice-President—C. T. HAINES, of Utica.
Second Vice-President—E. G. COX, of Albany.
Third Vice-President—W. H. BISHOP, of New York.
Secretary—DEWITT G. WILCOX, of Buffalo.
Treasurer—WILLIS B. GIFFORD, of Attica.
Necrologist—W. S. GARNSEY, of Gloversville.
Counsel—FREDERICK E. WADLAMS, Esq., of Albany.

The nominating committee for State Medical Examiners, consisting of J. B. GARRISON, A. G. WARNER, D. J. ROBERTS, F. W. ADRIANCE and C. R. SUMNER presented the names of J. B. GARRISON, New York City; E. W. BRYAN, Corning; WILLARD N. BELL, Ogdensburgh; GEO. M. DILLOW, New York City; ST. CLAIR SMITH, New York City; L. A. MARTIN, Binghamton, of whom the following were elected for appointment by the Regents: J. B. GARRISON, E. W. BRYAN, WILLARD N. BELL and L. A. MARTIN. Of these J. B. GARRISON and WILLARD N. BELL were appointed by the Regents.

Upon the election of candidates for State Medical Examiners, Dr. Gifford called the attention of the Society to its action some years ago, whereby it was agreed with the State Regents not to place in nomination the names of any men who were in any way connected as instructors with medical colleges. It was the action of the Society that in future no names will be received wherein such positions were held.

By motion of the Society, the dues of Dr. M. T. Dutcher, of Owego, were remitted, owing to his continued illness from paralysis agitans.

Dr. Moffat gave notice that he would introduce a resolution at the next meeting effecting a change in the by-laws upon the manner of electing officers, as follows:

"The Secretary be instructed to send a return postal card before January 1st to each active member of this Society, requesting a prompt expression of his or her preference for officers. From this informal ballot, the three names receiving the highest number of votes be considered nominated and a secret ballot by mail shall be taken by him.

The polls closed one week before our annual meeting. Both votes shall be counted in the presence of the President, who shall announce

the election at the February meeting of the Society, at which meeting the Secretary shall have present all the ballots."

By motion of Dr. Candee, and action of the Society, it was decided that the Society should hereafter hold an annual banquet at each Albany meeting and that a committee of five be appointed for such purpose.

A further resolution was adopted favoring the Bell bill and denouncing the Seymour bill, Adler bill and a bill which has been introduced into the Legislature, to the effect that it shall not be necessary for candidates for Commissioner of Lunacy to have five years' experience in treating the insane.

A bill of forty-five dollars was allowed the Legislative Committee for running expenses.

The following committee for naming candidates for State Medical Examiners for the ensuing year are: Bukk G. Carleton, New York; R. A. Adams, Rochester; Wm. Harvey King, New York; W. B. Winchell, Brooklyn; Martin Besemer, Brooklyn.

By invitation of Dr. Haines, the Society was invited to meet at Utica for the semi-annual session.

The following members were dropped for non-payment of dues: William H. Bleeker, Riverhead; L. W. Bolan, Brooklyn; George E. Bachman, Rochester; W. G. Birdsall, Clintondale; F. E. Rabe, New York.

Dr. Moffat gave notice that he would present a resolution at the next annual meeting to change the definition of "homœopathic physician" to read as follows:

"A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics and observes the law of Similia."

The following were elected Censors:

C. GRAY CAPRON, Utica, Middle District.
B. WILLIAMSON, Friendship, Middle District.
R. B. HOWLAND, Elmira, Middle District.
J. T. COOK, Buffalo, Western District.
J. M. LEE, Rochester, Western District.
J. W. CANDEE, Syracuse, Western District.
J. I. DOWLING, Albany, Eastern District.
S. T. BIRDSALL, Glens Falls, Eastern District.
D. E. SPOOR, North Granville, Eastern District.
GEORGE MCDOWELL, New York, Southern District.
W. S. MILLS, New York, Southern District.
R. K. VALENTINE, Brooklyn, Southern District.

The following is the report of the various chairmen of their respective bureaus which constituted the program presented:

## FIRST DAY—MORNING SESSION—10:45 O'CLOCK.

### BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

DR. FRANK B. SEITZ, Chairman, presented two papers:

"Why Are We Deaf?" by JOSEPH F. ROE. Discussed by E. ELMER KEELER.

"When Should the Oculist be Consulted?" by FRED D. LEWIS.

### BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

DR. F. W. ADRIANCE, Chairman, presented four papers:

"Some Clinical Experience with Echinacea Angustifolia," by ERMINA C. EDDY.

"Clinical Notes on Diabetes Mellitus," by C. G. CAPRON.

"The Advantages of Antitoxin in Diphtheria," by GEORGE E. GORHAM.

"An Unusual Fœtal Monstrosity," by GEORGE R. STEARNS.

### BUREAU OF PÆDIATRICS.

DR. F. W. HAMLIN, Chairman, absent; Dr. A. B. VAN LOON took charge. One paper presented.

"The Treatment of Lobar Pneumonia in Infancy," by A. B. VAN LOON.

### BUREAU OF LARYNGOLOGY AND RHINOLOGY.

DR. CHARLES E. TEETS, Chairman, absent; DR. F. D. LEWIS took charge. One paper presented.

"Are Deformities of the Nasal Septum Less Frequent Now Than Formerly?" by F. D. LEWIS. Discussed by A. WORRALL PALMER.

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## FIRST DAY—AFTERNOON SESSION—2:32 O'CLOCK.

### BUREAU OF MATERIA MEDICA.

DR. J. T. COOK, Chairman, presented three papers:

"On a Restudy of Materia Medica," by THOMAS C. DUNCAN, M. D., Chicago, Ill.

"Calcarea Carbonica," by WALTER SANDS MILLS.

"Gelsemium," by L. A. MARTIN.

### BUREAU OF OBSTETRICS.

DR. W. S. GARNSEY, Chairman, presented three papers:

"A Neglected Obstetrical Duty," by WILLIAM P. FAUST.

"A Peculiar Case," by HATTIE C. VAN BUREN.

"Sudden Rise of Temperature During Puerperality," by EMILY F. SWETT.

### BUREAU OF NEUROLOGY.

DR. J. T. GREENLEAF, Chairman, presented two papers:

"The Seventh Cranial Nerve," by P. W. NEEFUS.

"Is There a Distinctively Homœopathic Therapia in the Treatment of Mental Diseases?" by J. T. GREENLEAF.

### BUREAU OF GYNÆCOLOGY.

DR. A. B. VAN LOON, Chairman, absent; DR. E. G. COX took charge. Four papers presented:

"Diseases of the Right Ovary and Tube and Their Relation to Chronic Appendicitis," by W. LOUIS HARTMAN.

"Appendicitis with Abscess Complicated by Ovarian Cyst. Operation. Recovery," by EDWARD G. COX.

"Leucorrhœa, Its Diagnostic Value and Homœopathic Treatment," by H. D. COCHRANE.

"Should Cantharsis Precede Laparotomy?" by GEORGE W. ROBERTS.

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## SECOND DAY—MORNING SESSION—10:04 O'CLOCK.

### BUREAU OF PUBLIC HEALTH.

DR. C. A. WARD, Chairman, being absent, DR. F. PARK LEWIS took charge. One paper presented:

"State Protection in Animal Tuberculosis," by F. PARK LEWIS.

### BUREAU OF SURGERY.

DR. NATHANIEL ROBINSON, Chairman, being absent, DR. N. M. COLLINS took charge. Two papers presented:

"Fecal or Intestinal Fistula: Some Personal Observations On," by WILFRED G. FRALICK.

"The Importance of Early Diagnosis in Appendicitis," by NEWTON M. COLLINS.

Address by DR. H. M. PAINE.

"Efforts to Perpetuate Illiteracy in the Medical Profession Should be Emphatically Rebuked," by HORACE M. PAINE, Atlanta, Ga.

# REPORT

OF THE

## BUREAU OF OPHTHALMOLOGY AND OTOLOGY

"Why Are We Deaf?" - - - - - - JOSEPH F. ROE.
"When Should the Oculist be Consulted?" - - FRED. D. LEWIS.

## WHY ARE WE DEAF?

JOSEPH F. ROE, M. D.,
BINGHAMTON.

It is not my intention to ask your indulgence while I recount the numberless causes of deafness, but simply to present a few circumstances common to us all in which our action or inaction means hearing or oblivion to the patient.

Ear cases naturally divide themselves into two great classes, those which discharge and those which do not. This latter and larger class includes all those cases in which heredity, habits, vocation and chronic catarrh play the most common etiological part. These, after being duly Politzerized and dosed, become the natural stock in store of the aurist. These include secretive, plastic and purulent conditions of the eustachian tube; dry, inflammatory and exudative conditions of the middle ear, together with atrophy and hypertrophies of the tympanic membrane, and a score of ossicular, muscular and nervous affections of the tympanic cavity and inner ear. But different is the history of the purulent otitis media cases, in the interest of which this paper is especially designed. In these cases we have opened to infection the most delicate structures of the whole anatomy. In the etiology of otitis media, three causes are common to us all; the exanthemata, influenza and adenoids. So much has been said on the subject of adenoids in the past few years that I am sure we are all so familiar with the influence which it has upon the middle ear that no space need be given it here. Every epidemic of influenza or grippe is fruitful of a large percentage of cases of acute middle ear disease. Whether this be from a general systemic infection or from direct extension of the inflammation of the Schneiderian membrane, is still an open question. Whatever the poison of grippe may be, it is natural to suppose that a disease affecting the entire inner surface of the air passages with such a violent progressive

inflammation, would naturally, by direct extension, affect the middle ear. This, I believe, is the method of infection in these cases, inasmuch as most cases of grippe are productive of a greater or less sense of fullness and deafness in the aural regions. According to statistics, from two to three per cent. of all cases of influenza are accompanied by *purulent* otitis media. This must at once place grippe as a serious etiological factor in middle ear disease. Different is the history of cases secondary to the exanthemata. In these, scarlatina is the most worthy of our consideration. Here the disease of the ear appears only after the inflammatory stage of the scarlet fever is past. The theory of general systemic infection holds, inasmuch as the disease appears without any premonitory eustachian affections. While in influenza the character of the middle ear affections is of the highest inflammatory grade, scarlatina brings the most destructive and lowest form of the disease. In grippe a perforation of the tympanic membrane is only after from twelve to forty-eight hours of severe inflammatory invasion. In scarlatina the perforation often follows with more or less complete destruction of the tympanic membrane after only a few hours of pain and congestion. This specific invasion is not limited except by solid walls of bone, and thus Bezolt has found that twelve per cent. are accompanied with purulent inflammation of the mastoid.

It is not necessary to dwell upon the causes and course of these inflammatory conditions. Suffice it to say that twenty per cent. of all purulent affections are directly attributed to scarlet fever. What great care and responsibility must then rest with the practitioner who treats these cases. Not less so with grippe, since here even a larger percentage is furnished on account of its more general invasion and repeated epidemics. That neglect of the ears in this disease is common, aye, almost general, is an undisputed fact. With the greatest care does the successful practitioner watch his case of scarlatina for the first appearance of albumenuria, that he may check this dangerous complication at its onset. How often does he ask or watch for any appearance of ear trouble? As it does not immediately and directly affect life, it seemingly does not demand his attention; but alas! how far more doleful are the results of inflammation here than in the kidneys; the one kills, the other is a life punishment.

During epidemics, such as the recent one of the grippe, patients daily present themselves to the specialist suffering with a purulent condition of the middle ear and with a history of some weeks or months before having had grippe, pain in the ear, and then all that line of poultices and hot water bags and eventually a general rejoicing over a free discharge of pus! That these cases have in the majority been badly treated does not admit of a doubt. Had the practitioner at the onset of the disease examined the tympanic membrane carefully and noted the congestion along the handle of the malleus, a little care and diligent treatment would have saved much suffering and dire results, though it might have deprived the aurist of a case. I believe that no practitioner should consider himself competent to treat a severe case of scarlatina unless he were able to use the

otoscope and make a fair examination of the tympanic membrane. Then, at the first signal of inflammation here, he might, in not a small percentage of cases, entirely avert the disease.

As a rule careful use of the Politzer bag and ice, rather than the customary *poultice* would act favorably upon the inflammation which threatens here. Many times is the care of the ear, when pain appears, left entirely to the nurse or mother or some wise "tabby" who happens to be present. An examination of the ear is not hard even in the worst scarlet fever case, inasmuch as the canal is not so long or tortuous in the child as in the adult. Politzerization is also easy, as in the simple act of resisting the child naturally tightens his throat or closes it and thus makes the most favorable condition for driving air into the middle ear. That these things should not be neglected and that they are neglected is the experience of every man who attempts ear work. If the general practitioner realized the gravity of these cases, he would either prepare himself for this work or more often call the aurist in consultation in these cases. So rapid, however, is the progress of the disease in scarlatina cases that the mischief is done before the practitioner realizes that an otitis media is developing. In otitis media accompanying grippe, however, there is no excuse. Here pain is continuous and severe for hours or days and ample time is given to make any examinations or administer any treatment. Here, too, on account of rarification of air in the middle ear, should the Politzer bag be used, and this failing, a paracentesis should be made in the drum membrane. This incision should be in the lower posterior quarter and perpendicular to the fibres of the membrane. The incisions thus made in any case of otitis media heal more rapidly than does the natural opening made by the pressure and burrowing of pus.

In my title , "Why Are We Deaf?" I do not mean to lay deafness in general at the door of the practitioner, but that hundreds of cases annually are produced by the neglect of the general practitioner, I firmly believe. Such cases as the following are not uncommon, but present themselves daily to the aurist.

CASE No. 1.—F. E. S. Man, age twenty-five; good health generally; reports under advice of friends; had grippe two months ago; began with severe headache and earache. Under advice of family physician poultices were used to both ears and after about two days both ears began discharging pus freely; patient now very deaf; under examination each tympanic membrane is about two-thirds gone and severe inflammation of tympanic cavity. Since the time of the first appearance of pus, no local treatment has been given, neither has any examination of the ear been made.

CASE No. 2.—Girl; age five years. Five months ago had scarlet fever with severe otitis media in both ears. Advised by physician in charge that it would be dangerous to stop the discharge from the ears. Mother, however, tells me that she has used daily sweet oil and castile soap in each ear. The left mastoid is involved and has two large openings discharging pus. The right side ceased to discharge after about the first month.

These cases are only samples of hundreds and are not presented to show the good results of treatment, but simply the bad results of such absolute neglect. Nor do these cases come from a physician who has no standing, but have been in the hands of our best general practitioners. Therefore, this paper is written as a plea to the general practitioner to make more careful examinations and watch for the development of ear troubles in grippe and scarlet fever and kindred diseases with the same regularity with which he would examine the urine or ask to see the tongue.

If I have made one practitioner thoughtful of his responsibility in these cases, this brief article has not been written in vain.

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## DISCUSSION.

DR. KEELER: As Doctor Roe has written this paper with the avowed intention of making it a "plea to the general practitioner to make more careful examinations and watch for the development of ear trouble in grippe, scarlet fever and kindred diseases" it would seem appropriate in opening the discussion to emphasize one or two points along the same line of argument.

It may be stated with little fear of contradiction that if the general practitioner treated every case in an absolutely perfect manner there would be little need of the specialist. Each case would be cured where a cure was possible. It is in just these cases that the need of the specialist becomes apparent. The need of some one who, in La Grippe, fevers and kindred diseases, will be ready to counsel, to make an endeavor to prevent complications, and to be an aid to both physician and patient. No general practitioner can honestly say in such cases as Dr. Roe has related, "Well! I did the best I could!" "No! You did not! You should have sent for Dr. Roe or some other competent specialist before this condition developed!" The general practitioners outside of the larger cities are slow to learn that every time they call a specialist to one of their families, and he is able to do something to relieve, prevent or cure an obscure disease, just so often the physician has gained in the respect and confidence of that family. The time has passed when the general practitioner must pretend to know it all.

Dr. Roe speaks of the ill effects following the use of the old-fashioned "poultices" and we all know how difficult it is to prevent their use in every case of pain in or around the ear. They are always an offense to the eye and frequently when they are mixed with the succulent onion they become a veritable insult to the nose. At their best they are disagreeable, at their worst they are destructive.

I have found that where poultices have been discarded for the more rational use of hot water, that even then complications may arise from its long continued use. I have met with a great number of cases where hot water had been used *ad libitum*. Quarts had been forced through the nares, and gallons had been projected against the

sensitive tympanum. In one instance which I have reported to the Journal of O. O. and L. the physician had directed the use of water as hot as the patient desired used by means of the fountain syringe elevated several feet above the head of the patient, and this mode of treatment had been followed for three weeks, when the pain having ceased, the patient was discharged as cured. Within a few days I was called on account of the great deafness which persisted. Upon inspection, the meatus was discovered to be nearly filled with an ugly discharge, which came from the middle ear through a large perforation in the tympanum. At the time when the patient had been led to suppose that she was cured she was told that the ear was absolutely valueless until a series of thorough treatments should be instituted. It is in such cases as these that the general practitioner loses the confidence of the patient he has so long and carefully labored to obtain. You do not hesitate to call in the surgeon in a case of even suspected appendicitis, and yet here is a condition where if the right thing is not done at the right time the individual is frequently doomed to a lifetime of suffering.

Learn this lesson from the excellent paper before you. Examine each case where there is even a suspicion of ear complications. Examine it thoroughly, and frequently, and if at any time you find conditions concerning which you are in doubt, give your patient the benefit of the doubt.

Preventive medicine is the medicine of the twentieth century, and if you follow this line of practice you will have the calm satisfaction of knowing that you will be the means of preventing many cases of serious and sometimes incurable deafness.

DR. MOFFAT: I want to caution everybody as to the danger of applying ice to the head. It is an invaluable remedy for many of these ear cases, especially in the first stage; but we forget, when applying ice, that we drive the blood from the superficial to the deeper tissues. A woman who had a shock on top of prolonged nerve strain relieved her confused, congested sensation by the continued application of ice for a number of hours. Although I stopped this, in a few days she developed acute mania which became so violent that we sent her to Middletown, where—I am happy to say—she was cured in six weeks. I am sure that if the ice had not been put on her head she would not have become insane. So with the ear; if we are not careful how we apply ice we may determine an inflammation of the internal ear, or within the cranial cavity, which is more dangerous and difficult to cure. I would like to caution the general practitioner that babies crying with pain may have earache. It requires discrimination and careful examination to determine that the pain is in the ear. I am talking now, of course, in case we have no otoscope with us. Observe the effect of warmth, of pressure about the ear, or on the mastoid, and of pulling the ear carefully, comparing the two sides. Of course, otoscopic inspection should always be resorted to if possible. Scarlet fever, grippe, or measles may not appear to have attacked the ear, yet may leave a chronic pharyngeal or nasal catarrh which is one of the most dan-

gerous and remote causes of an insidious deafness. The patient should not be dismissed as cured if any catarrh persists after the attack.

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## WHEN SHOULD THE OCULIST BE CONSULTED?

FRED. D. LEWIS, M. D.,
BUFFALO.

I have chosen the above subject for my paper to-day, because I believe that the importance of the eyes in relation to the general health is not sufficiently understood by most physicians. It has been said that men working in a particular line, after a time, become cranks. This may be so, but it is the result of the evidence that has been presented to them, in that particular line of work, that has placed them in advance of their fellow men, and their statements ridiculed to-day may be seriously considered at a later time. That all the ills that flesh is heir to have their origin in eye strain would be an an absurd statement, yet I believe that many of the troubles that are most perplexing and cause their physicians the greatest trouble would respond more readily to the indicated remedy, or be cured without remedy if the conditions of their eyes were recognized and corrected. Our patients have learned the importance of consulting a dentist at regular periods to anticipate trouble with their teeth, rather than wait for cavities to be formed and then trying to have them repaired. Are the eyes of so much less importance than the teeth that they must cry out for help by causing headaches, or other troubles before an oculist is seen and consulted in regard to them? I think not, and I have a number of families now on my books, who, when their children are seven or eight years old, bring them to have any defects corrected before their hard school work begins. The results of this will be seen in the years to come, when these children will develop into stronger physically and finer mentally men and women than their fellow school mates, who have been wasting nerve energy, in the attempt to overcome an eye strain, that should have been economized and put to better use. Of all the senses we possess, that of vision uses up the most nerve-energy. With an eye so slightly defective that the defect can be easily overcome, the amount of nerve energy expended in overcoming such defect, during twelve or fifteen hours daily, in the course of weeks, months or years is simply enormous. With this great waste other organs may be deprived of the requisite amount of nerve force to conduct their functions. Thus with perhaps a congenitally weak stomach, indigestion would result; weak kidneys might develop rheumatism through their inability to carry off the waste products, a heart of insufficient strength might manifest dilatation, etc., etc. I

go further than this and say that with an eye strain the whole physical development of the child may be retarded. With a waste of nerve force during the growing period of the child, and that waste increased by the school work required during this period, is it not natural that the tissue building must be hampered, with the result of imperfectly formed bodies and less vigorous minds? Granting this fact, is that child not more prone to fall a victim to prevailing diseases, and in consequence can it have a life as long as that of one not laboring under like disadvantages? I say no, and, thus by neglecting to correct the error, the child's existence is made less happy and its life cut short by perhaps years. I believe the time is coming, and I think we will all see it, when no advanced physician will take a case of any length of standing, such as indigestion, rheumatism, gout, chronic ovarian or uterine trouble where it is not clearly indicated in the surgeon's sphere, etc., without having the eyes examined first, to see if they are not a leading factor in the cause of the trouble. Glasses are but a remedy, and like all and other remedies if needed they are needed very much, and if not needed they will do harm. However, there is this difference that unlike a drug remedy that is to act for hours or possibly days, their action is to extend over years, and in consequence should require more study and greater care in their selection. If the selection is a good one the results are sometimes most surprising—a few examples may illustrate my meaning:

CASE 1. A few years ago a stranger who was spending his vacation in the Pan-American City called on me seeking advice in regard to his indigestion. He being a stranger did not know that I did no general practice so I referred him to a stomach specialist. The doctor gave him a test meal which on examination proved that the stomach was not secreting digestive fluid. No physical cause could be found to account for this so he sent him back to me to examine his eyes. The patient said he was a school teacher from New Hampshire, used his eyes constantly, had no headaches, and as he expressed it, was not conscious that he possessed eyes. An examination revealed rather a high degree of astigmatism at unsymmetrical angles. Glasses ended his indigestion without the aid of drugs of any kind.

CASE 2. This case was my brother's, but came under my care for a time during his absence from the city. The lady had rheumatism of some length of standing, with joints enlarged to almost twice their natural size. There was great difficulty in moving even for short distances with the aid of canes. She had been treated by several physicians without benefit. The examination of her eyes revealed a high degree of hyperphoria which was corrected. Result, the rheumatism gradually disappeared without the assistance of internal medication.

CASE 3. The wife of one of the motor men on our city trolley cars came to me for the relief of her headaches; I found a small amount of astigmatism, the correction of which stopped the headaches at once and she reported to me after two weeks that she was sleeping better and feeling much more rested on awakening. Her

husband went on duty at eleven o'clock each night and was in the habit of saying "Good-night" to her on leaving the house; she always responded to his "Good-night" until she got her glasses, but after that she did not hear him.

CASE 4. My own case is perhaps the most convincing of the necessity of correction of eye strain that I have seen. In 1895 when on my way to Europe I stopped in Philadelphia for a few days, when I called on my friend, Dr. Gould. In speaking to him he kindly offered to examine my eyes for me. I had no idea I had any trouble as I never had a headache, could see perfectly for distance and reading, but availed myself of the opportunity of having my judgment confirmed by a man of Dr. Gould's standing. To my surprise he found astigmatism of unequal amount and angle and on prescribing my glasses said I might take them off when I went to bed and when I died. For six months after wearing them I noticed no difference but after a year and two years I found I was doing more work and better work with less effort than I had ever been able to do before, and I feel satisfied now that had my eyes been corrected before I went to college I would have graduated with higher honors. I simply could not do the reading and study that mv fellow students did. In my efforts to do so I would go to sleep. Nature could not stand the strain and drew the curtains.

The subject of this paper was suggested to me by cases that I have had referred to me on many occasions by opticians who could not make satisfactory refractions, the cases coming to my office remarking that their physician deeming it necessary that they have glasses had told them to go to an optician and be fitted. I hold that the optician has no more right to prescribe glasses than the druggist has to prescribe medicine.

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## DISCUSSION.

DR. BUTLER: Any other remarks to be made on this paper? It seems to me that this subject is exceedingly interesting and very timely. The longer I practice in my specialty the more I am convinced of the absolute necessity of every one's consulting frequently an ophthalmologist. I never treat a case of neurasthenia without having his eyes looked at. Chorea, epilepsy, nervous dyspepsia, insanity; in fact any nervous trouble is liable to be brought on by strain of the eyes. A case of epilepsy was sent to me by a brother practitioner and in two days this man had forty fits. I prescribed as carefully as I could. One dav I noticed he had some very peculiar looking glasses on. I said, "What are those glasses?" He said, "They are my grandmother's." He said that he had been wearing the glasses. I sent him to Dr. Warner and he adjusted some glasses and for a year and a half that man never had a convulsion. These convulsions, which were grand mal—one of the severest forms of epilepsy—were due entirely to this eye-strain. We

often lose sight of it as in a case of nervous dyspepsia where there is an eye-strain that has kept up just enough irritation to upset the stomach, and it is the last thing that one is apt to think of, namely, the eye in connection with the stomach. I do not believe that all cases of chorea can be cured by adjusting proper glasses, yet I know it has a very marked effect in many cases. I think this is a paper which is very timely, and we are under obligations to Dr. Lewis for having read it.

Dr. F. PARK LEWIS: If there is any one thing that characterizes the modern physician in the new school of practice it is an aim to find the causes of disease. That is particularly so, I think, in regard to diseases of nutrition, but in all diseases the first aim of the careful physician is to find not only what the disease is but why it exists. That can only be done by making a thorough and complete examination of all the conditions of the patients. Until the eyes have been examined in any disease, there has not been made a careful or complete examination of the patient. Therefore, no physician is justified in saying that he has arrived at the origin of any disease until he knows what effort the patient may be making in the endeavor to see. He may be making an unconscious effort which directly impresses the central nervous system in the most marked and profound way. I know it rarely happens that two sides of the human being are alike. The nose is almost never directly in the center of the face; the two eyes are not of the same height; very frequently one eye protrudes more than the other. The cheek bones are not alike. Symmetry is a rare thing in the human being. The work of the oculist demonstrates that it is almost equally rare to find absolute symmetry in both eyes. If two eyes are unlike, or if the foci of the two meridians of the same eye are unlike, and more especially still where the angles of asymmetry are not co-ordinate, the effort that the individual must be making constantly to get a co-ordinate focus, is very great. It is curious that this does not show itself in pain in the use of the eyes, and, as in one of the cases cited, it is a matter of very constant experience with all oculists to find eyes that appear to the patient to be absolutely comfortable, giving no evidence of distress in using them, and which may still be so widely different in focus and may be so far removed from a normal refractive condition, that the effort in combining the focus of the eyes is very great. The form in which strain manifests itself frequently is in the secondary digestive tract. We find our specialists in diseases of the stomach are treating this class of diseases by excluding the starches and sugars and by giving specifically a meat diet with the effect of giving relief during the time that kind of diet is continued; but we must bear in mind that there exists a reason always for the inefficiency of the secondary digestive tract. Taking away from the patient those foods is not curing the disease, but simply giving alleviation for the time. The careful physician will find out when the secondary digestive tract is not doing its work as efficiently as it should. In a very large number of cases I find that one of the contributing causes, persistent eye-strain which

need not necessarily be indicative of a high degree of focal irregularity. In no nutritive or nervous disease has an examination been completed until the physician who has treated that disease has a record of the focal conditions of the eye.

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# REPORT

OF THE

## BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

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"Some Clinical Experience with Echinacea Angustifolia," ERMINA C. EDDY.
"Clinical Notes on Diabetes Mellitus," - - - C. G. CAPRON.
"The Advantages of Antitoxine in Diphtheria," - GEO. E. GORHAM.
"An Unusual Fœtal Monstrosity," - - - - GEO. R. STEARNS.

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## SOME CLINICAL EXPERIENCE WITH ECHINACEA ANGUSTIFOLIA

E. C. EDDY, M. D.,
ELMIRA.

In a short paper I wish to call your attention to a few cases treated with echinacea. This remedy was known to the Indians and Quakers long ago, but only brought to the attention of the medical profession in recent years. It is not yet thoroughly proven, but each year adds to our knowledge of its possibilities as a helpful factor in the treatment of disease, especially all septic conditions. My experience has been with the tincture, which, I think, is preferred by most physicians. But more knowledge of the drug may lead us into the higher attenuations.

CASE I. Mr. L., aged 83. Temperate; general health good. Sore began on heel, simulating frost bite, but later developed typical senile gangrene. Patient objected to an operation, and I found no surgeon anxious to operate, owing to his advanced age, enfeebled condition, and depleted pocket-book. Disease progressed slowly for a time, until sloughing occurred. Then he suffered much pain, with more rapid involvement of tissue. At this time my attention was called to echinacea ang. Began using a lotion of echinacea $\theta$ one part to three of water. Also giving internally 10 gtts. three times per day. The

beneficial effects were soon apparent in diminished odor and less rapid destruction of tissue; but was soon obliged to discontinue its use, owing to the increase of pain caused by any lotion in contact with the sore. Cerates were more soothing. Had I then known of Dr. Hamlin's excellent ointment,

Echinacea tinct. ℥ ss.
Lanoline ℥ j.
M.

should have given it a trial. Not with the hope of curing my patient (for he was beyond that), but to diminish the odor and make the atmosphere of the room more hygienic, for he lived until the whole foot was involved, and the toes dropped off one by one; being fifteen months from the initial lesion. The later treatment consisted of echinacea θ and arsenicum alb.$^{6x}$ internally, cleansing with peroxide and dressing with charcoal.

CASE II. Miss R., aged 40, came to my office complaining of loss of appetite, sleeplessness, debility and an excoriating leucorrhœa with very offensive odor. Internal medication, together with carbolated douches, had been used with no apparent result. Examination revealed endometritis with erosion of cervix. Leucorrhœa thick, yellow and *very* offensive. Treatment consisted in cleansing the parts thoroughly and applying tampons, saturated with a solution of echinacea θ, glycerine and water, equal parts. When tampon was removed patient used a douche of hot water, followed by 4 ℥ of water the same temperature, medicated with echinacea θ ʒ j. Internally, echinacea 10 drops three times per day. The improvement was rapid and permanent.

CASE III. Miss H.; domestic, aged 23. Complained of feeling so tired that she could neither eat nor sleep. Continued working in that condition for two weeks, growing very weak and nervous, but had no pain. Came to my office to get medicine for her "nerves", and I found temperature 104, pulse 130, respiration 24. Tongue brown and heavily coated, breath very offensive. One daily evacuation. No tympanitis nor soreness of bowels. Put her in bed, and ordered liquid diet, following all precautions customary in typhoid fever. Using the indicated remedies which included baptisia: bryonia; gelseminum and hamamelis. Within twenty-four hours had three characteristic stools. Twelve hours later a profuse hæmorrhage, dark and very offensive. This was followed by two more within twelve hours. Lighter color and less in quantity, but still the same carrion-like odor. Notwithstanding great carefulness on the part of the nurse, the odor from breath and excretions was almost unbearable. Then we began the use of echinacea θ 15 drops thrice daily for three days, followed by 10 drop doses twice a day until convalescence was established. An improvement in temperature and general condition was apparent in a very short time, and continued. Had I used the echinacea sooner many of the unfavorable symptoms might have been aborted.

Echinacea exerts a decided influence on the blood and mucous

surfaces. Hence in cases of cancer many of our best surgeons who believe that malignancy is not local, but constitutional, use the knife freely, and then give echinacea continuously for six months or one year with excellent results.

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## DISCUSSION.

DR. SPOOR: I have a patient who fell down stairs and hurt herself considerably and for a time she was in a very serious condition. After improving she was taken with a pain in the limb where she had a varicose ulcer and from that it went to the large toe of the same foot. The toe turned black, dry gangrene set up and the whole toe-joint has withered until now it is not larger than my little finger and is gradually coming off. The reason it was not amputated is because the woman had a very bad heart and could not take an anæsthetic and, therefore, it has run along as it has. I put her on echinacea and she has taken it for a long time. The inflammation entirely went out of the foot, around the edge of the gangrene the line of demarcation has entirely healed and the toe is gradually coming off at the first joint. She has had no bad symptoms since she began to take the echinacea and has improved in every way. Her general health is as good as before her fall, but the toe has not come off as yet.

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# CLINICAL NOTES ON DIABETES MELLITUS.

C. G. CAPRON, M. D.,
UTICA.

During a short stay in Philadelphia, last summer, I had the pleasure of meeting one of our college professors, a man of large experience and excellent reputation. During the conversation he mentioned the fact that to his remembrance he had treated only three cases of diabetes in twenty-five years' practice. It then occurred to me that my few cases, were I to report them, might be of some slight service and I therefore present the following cases for your consideration, which represent an experience of ten years' observation. They are not offered as embodying anything particularly new, simply my treatment of this dread malady. In the declining period of life we can generally influence the progress of the disease, but in the young, I am sorry to say, our efforts seem of less avail.

CASE I. E. L. McL. Single, age 26, bank clerk, slight build, dark complexion, Scotch parentage, family history negative, no apparent cause. Urine 1034, complained of thirst, malaise, copious urination.

Large percentage of sugar on examination. Put on strict diabetic diet. Remedies: arsen. brom., phos. acid, uran. nit., stron. iod., nux vom., podoph. 1-10 gr., stron. salicylate, codeine. Under observation two years, duration of illness three years, died in diabetic coma lasting fifteen hours—at work thirty-six hours before death.

CASE 2. Mrs. L. W. B. Age 29, slight build, dark complexion, has had two children, usual symptoms of the disease, no apparent cause. Urine 1030 to 1038, sugar abundant. Spent summers at seaside where she always seemed to improve. Given restricted diet as strict diet seemed to completely prostrate her. Remedies: stron. salicylate, arsen. brom., codeine, nux vom., podoph. 1-10 gr., hydrastis. Under my care eighteen months, duration of illness four years. Died of diabetic coma lasting twenty-four hours. Two days before felt unusually well and attended a reception.

CASE 3. O. C. Married, age 76, contractor, rather heavy. Welch parentage, twenty years previous had meningitis in severe form, to which he attributed the cause of present trouble. Urine 1026 to 1040. Had been a heavy stimulator. Feet, ankles and hands considerably bloated. Restricted diet. Remedies: infusion digitalis, stron. salicylate, codeine, nux vom., hydrastis. Under observation three years, duration of illness eighteen years. Died of heart failure, conscious to within a few minutes of death.

CASE 4. W. C. S. Married, age 60, commercial traveller, rather fleshy; first noticed thirst and copious urination: has not felt badly at any time. Urine 1032 to 1038, sugar abundant. Limited diet. Patient is now feeling better than at any time since trouble began, but sugar is more or less constant, depending on his care of himself. Remedies: stron. salicylate, Stafford water. Has been under observation about two years, duration of the disease about seven or eight years.

CASE 5. D. M. J. Married, age 57, hotel keeper, light complexion, probable cause, excessive beer drinking. Urine never over 1024, sugar transient, has albuminuria also. Has been to numerous water cures, Hot Springs, Mt. Clemens, etc. Strict diet at first, then restricted. Kept him on hamburg steak and hot water for six weeks. Marked improvement in urine followed, also great bodily prostration. At present feeling very well. Remedies: nux vom., hydrastis, kali iod., arsen. brom., Stafford water. Under observation seven years; duration of illness twelve years.

CASE 6. W. H. G. Married, age 61, very obese, 225 pounds, fair complexion, Scotch parentage, had syphilis at 23, polyurea, great thirst and weakness. Urine 1036 to 1040, has had the disease so far as known eight years. Has not lost in weight at any time. Diet strict, then limited. Remedies: stron. iod., later stron. salicylate, nux vom., hydrastis, podophyllin 1-10 gr. Under observation three years; continues to feel well.

CASE 7. R. O. T. Single, age 23, fair complexion, slight build. Would take remedies but would not diet. Ate freely of starches and sugars. Remedies: arsen. brom., podophyllin 1-10 gr. Went to Florida and died there of diabetic coma lasting eighteen hours, hav-

ing had the disease, so far as known, only two and one-half years. Saw but little of this case.

CASE 8. W. P. B. Married, age 61, merchant, heavy in stature, has suffered much from sciatica, been to many watering places and sanitariums. Urine 1026 to 1040, sugar transient. Does not lose in weight, and at present feeling very well, even vigorous. Has had all kinds of diet and many remedies; best results from rhus tox., stron. salicylate and podophyllin, Turkish baths and Stafford water. These notes serve to illustrate the weak resisting power of the young for this disease. Three died under thirty-five years of age, while those over forty-five live on and do not seem greatly inconvenienced by their malady.

In all my cases the sugar could be removed by diet alone although some remedies seemed to hasten the process. Also as the sugar lessened the quantity of urine decreased. A strict diet surely modifies symptoms, yet to my mind a limited diet, after once having the disease under some control is far better. The so-called "Salisbury diet" seems to me to be of little value. It will clear the urine of sugar rapidly, but leaves the patient in such a prostrated condition that one hardly feels that the end justifies the means.

Eliminating the sugar, lessening the quantity of urine and diminishing the weakness if possible, is a step in the right direction and can be accomplished by other means less vigorous than that of Salisbury. The discontinuance of all sugars and starches is a necessity for a time but often we can return to them later in limited quantities with decided benefit. In diabetes there is usually a lack of desire for food, especially of the kind that such patients should eat, and for this condition nux vomica and hydrastis, alone or in combination, in ten to twenty drop doses of the tincture before meals will restore the appetite to a more normal state. Our allopathic brethren tell us the sovereign remedy is opium or its alkaloid codeine, yet they say it is of no use except for a short time. So far as the short time is concerned I am with them, in fact, the shorter the better. I have tried it in nearly every case and it produces just the condition I do not want, viz., constipation. It has been my experience that all diabetics have a very sluggish condition of the bowels and I much prefer a "starter" to a "stopper" if I may be allowed the expression.

Constipation is best obviated by podophyllin in 1-10 gr. doses, three or four times daily. I have tried many drugs and waters, but for steady work the mandrake has given me the best results. The salicylate or iodide of strontium in five-grain capsules has seemed to aid in lessening the sugar and patients seem to feel better while under its influence. In conversation with one of my diabetics a few days ago he said: "My main dependence is on podophyllin, a limited diet and Stafford water." Stafford water is obtained from a town called Vossburg, in Mississippi, and I can speak volumes in its praise. I have allowed patients to eat baked potatoes, rice, buckwheat cakes and maple syrup in small quantities, the urine being loaded with sugar and of a high specific gravity. This water in ten days' time and in the face of this diet would bring the urine down to 1020 and clear

it of sugar as thoroughly as if it had never been present. Clifford Mitchell, of Chicago, highly recommends the Allouez water of Green Bay, Wisconsin. I have had no experience with it but Dr. Mitchell's word should be a sufficient guarantee of its efficacy.

Five grain doses of benzoinate of guiacol has many supporters but I have never been fortunate enough to get the benefit claimed for it. Jumbul has been a very fashionable remedy, but disappointing, and so one might go through the entire list of remedies recommended. "Many are called but few chosen."

A drug specially indicated may meet certain symptoms, but the few before mentioned are the ones I have mostly used. I am now trying the double bromide of gold and arsenic and hope for some favorable results. Turkish and vapor baths are of benefit to some, but each case must be individualized according to the symptoms presented. For the diabetic coma I can offer nothing of importance.

Heart stimulants hypodermatically—croton oil—and the introduction into the system of large doses of soda bicarbonate, one to two ounces every three hours, either by stomach or rectum. Inhalations of oxygen gas often repeated, normal salt solution per rectum, all have been tried and I must candidly say if any benefit was gained it was surely temporary and very slight. In the care of a patient suffering with this disease I am sure many of us feel like an eminent author who has said: "Diabetes is one of the most elusive maladies with which we have to deal. One is often struck by the fact that in treating it every man seems to work best with his own tools; that is, one will cure his case with arsenic, another with codeine, another with uranium and another with jumbul, yet when I try any or all of these I cure nobody with them."

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# THE ADVANTAGES OF ANTITOXIN IN DIPHTHERIA.

GEO. E. GORHAM, M. D.,
ALBANY.

The advantages of diphtheria antitoxin in the treatment of diphtheria (the title of my short paper) may be mentioned in a few words.

First. Diphtheria antitoxin, when given early enough and in sufficient doses, cures diphtheria and when we consider what such a statement means—that a malignant zymotic disease for which there was never known a cure before, may be cured in from twenty-four to forty-eight hours with diphtheria antitoxin, it would seem we had said enough of its advantages. Other points, however, may be men-

tioned. One single dose administered by the physician himself often does the entire work. What an advantage over sprays and gargles, pills and powders administered day and night for several days, while intense anxiety on the part of friends and physician and great suffering on the part of the patient are the usual accompaniments. I have stated that no other cure is known for diphtheria. I do not say that other lines of treatment have not been applied and patients recovered, but in all former treatments the disease has run its course. Many patients recovering, but this does not prove that the treatment cured. With diphtheria antitoxin the whole process can be arrested and often within twenty-four hours the patient thoroughly convalescent. Again it can and has been proven that no bad results follow the use of diphtheria antitoxin when properly administered. A potent and sterile antitoxin, a sterile syringe and complete aseptic technique are the requirements. I expected to have a long list of statistics to prove my assertions, but have failed to get them fully arranged. In a general way I will only mention some of them. In Albany, diphtheria antitoxin is generally used and since its use Dr. Wm. H. Hailes, who had done nineteen-twentieths of all intubation for years, tells me that his work in intubating has fallen off ninety-five per cent. In the Albany Orphan Asylum during the last year thirty cases of diphtheria occurred and were treated by antitoxin. All recovered; most of them in from twenty-four to seventy-five hours. St. Margaret's Home and The Child's Hospital have also had as satisfactory results.

My personal experience, which converted me, was given in a paper before this Society at its last semi-annual meeting. The following letter from Dr. Burrows is of interest:

544 Massachusetts Ave., Boston, Mass.,
October 3, 1900.

*Dr. Geo. E. Gorham:*

My Dear Doctor—Your note of the 29th ult. has just reached me owing to the fact that I am no longer at the hospital.

I am sorry that we have no recently published statistics on antitoxin, but can say that we give it freely and repeat often 4000 unit doses every four hours. In severe cases we sometimes double the dose. Some patients have received as much as 80,000 to 100,000 units in all. The results of this line of treatment have been the lowering of the death rate from 45% to 12% in this hospital.

Of course you know that the worst cases and the neglected cases are the ones sent to hospitals.

The death rate for the city of Boston has been reduced from 30% to 10% during the past six years. The same results have been obtained wherever antitoxin has been used.

I am sorry that I have so little time in which to answer your note or I would look up some figures for you.

Regretting the fact that your letter was waylaid so long, and hoping this will reach you in time to be of service, I am,

Very sincerely, FRED G. BURROWS.

## DISCUSSION.

DR. GEORGE E. GORHAM: I am sorry to give so short a paper and not give the statistics. I had them, but could not get them arranged.

DR. WALTER SANDS MILLS: I would like to ask the essayist why, if any method of treatment before used has never cured diphtheria, the statistics of homœopathy are so much better than those of the old school. I should also like to know why some of the people who have had the most experience with diphtheria antitoxin have declined to use it on their own persons when taken sick. There is no question about the fact that there has been a vast improvement in the results of treatment of diphtheria at large, but the query is: Is not homœopathy just as good as the antitoxin? I personally know a man who has treated thousands of cases of diphtheria, who is connected with the Board of Health of New York. When he was ill himself he declined to have the antitoxin injected into his own person.

DR. MOFFAT: The old story of enthusiasm. We do not want to be stampeded by it, and I do not think we will be. As a homœopathic physician I have sometimes failed to cure diphtheria homœopathically. I have cured diphtheria with antitoxin, and have been surprised with its beautiful results. Such enthusiastic statements really hurt the cause of antitoxin. The doctor can't convince me and the Society that the whole experience of the world has been upset and that we have found a specific for any disease. Statistics will not uphold him that there has been no failure with antitoxin in diphtheria. I do not think he meant to say that; his statements were too sweeping. I think the thing to do in our homœopathic societies to-day, as scientific men, is to bend our energies toward ascertaining whether this remedy is homœopathic and to ascertain the indications upon which it should be used, i. e., to individualize it. I am not satisfied that it is homœopathic at all. We have had one or two papers claim that it is homœopathic because the serum, the poison, has been diluted through the blood of a horse; but I claim that we do not treat a disease homœopathically unless our reason for giving the remedy is based on the law of similia and we know the effects of the drug upon the healthy. We practice empirically, allopathically and homœopathically, but we ought to know which each time.

DR. GWYNN: I did not understand Dr. Gorham to say that he regarded antitoxin as an absolute specific for diphtheria; but I do think that any physician who has used antitoxin, within the last two or three years, and previous to that time had had from five to ten years' experience with the ordinary treatment, either homœopathically or allopathically employed, is willing to say that there has been a great stride forward in results since his employment of antitoxin. In my own family there have been, within the last year, two cases of membranous croup, each in children under one year old. For forty-eight hours previous to the use of antitoxin, the ordinary treatment had been faithfully employed. In both instances the children

were steadily growing worse. Within six hours after the use of the antitoxin, there was a marked improvement in each case, and in twenty-four hours both of the children were out of danger. For ten years prior to 1898, I had employed homœopathic remedies most conscientiously. The results in diphtheria were fair, but the results in membranous croup were absolutely nothing. For the last two and one-half years I have employed the antitoxin and have repeatedly demonstrated its efficiency. In fact, I have not lost a case during that period. Local treatment has been practically nothing, but when the diagnosis has been confirmed microscopically and clinically (especially the latter) the antitoxin injection has been followed in from twelve to twenty-four hours by improvement and rapid recovery. The injected cases have been my worst cases. They have occurred in families, in whom, in the same epidemic, other children had gone on to fatal issue under other treatment. Other physicians had employed the ordinary treatment. The cases were in houses already infected with the germs and toxic exudations from the throats of other children. There had been no opportunity for thorough fumigation. The cases that received antitoxin were most marvellously improved. The supportive treatment was rigidly observed. Milk and whiskey and good meat broths were constantly used to keep the vital forces at their highest point. Every case made a rapid and complete recovery.

DR. FAUST: One who has treated diphtheria with the well tried homœopathic remedies before the introduction of antitoxin and compared the results at those times with the results after the introduction of antitoxin cannot but favor it. I thoroughly endorse Dr. Gorham's paper that antitoxin does cure. One case in particular I call to mind, to which the largest amount of antitoxin ever used in my practice was given. It was a child. I had called at six in the evening and the pharynx was covered with a diphtheritic deposit. Culture was taken and two thousand units of antitoxin given. On account of the child's condition stimulation was at once resorted to. The membrane began to spread rapidly and in six hours I gave four thousand units more and in twelve hours an additional two thousand units. The membrane seemed to come forward on the roof of the mouth. The patient was profoundly septic, so much so that we had almost begun to think there was nothing to be done. That patient recovered, although for three months following I had a case of albuminuria on my hands. I would like to have some one tell me whether that was caused by diphtheria or antitoxin. The text books tell me diphtheria produces it. In nine cases out of ten I think the albuminuria is rather the result of diphtheritic poison.

In reference to Dr. Moffat's suggestion as to antitoxin being homœopathic we, every day, use not only homœopathic medicines but others and we do cure our patients. We have all cured them homœopathically, but I still contend that with a remedy which has given us the results and assurance that antitoxin has, every man who has a great deal to do with diphtheria cannot but endorse it.

DR. FISKE: I have passed through quite a number of epidemics of

diphtheria in my practice, and I remember at one time I really became quite proud of my success in curing diphtheria. During three epidemics covering a period of five years I did not lose a case, and I then lost three cases in one family. I have felt, on comparing the cases under my hands through the treatment of antitoxin and the cases it has failed in curing, they have been fully as numerous as the cases lost by good homœopathic treatment. In some of the recent decisions in the French and German papers we find that in Paris, where they have been using antitoxin to its fullest extent, the death rate in diphtheria has increased; that in Germany, among some of the best and foremost physicians, they are losing all faith in diphtheritic antitoxin; that the using of it simply on the strength of Klebs-Loeffleur bacillus as a diagnosis is not to be relied upon; that the only true reliance to be placed upon it is upon the clinical observation of the symptoms taken in *toto*. I have seen a case of diphtheria which covered the whole fauces, the posterior nares, the anterior nares, coming out over the lips and cheeks, cured with homœopathic remedies. That we call a pretty severe case. If it was treated by antitoxin and the same result occurred, we would give antitoxin all the glory. I myself have used antitoxin; I have waited after using homœopathic remedies and used it simply to protect myself, feeling the patient would die anyway and did die; and I have used it early and felt that if I had stuck to my homœopathic remedies the case would have gotten well. I think Dr. Gorham takes a very enthusiastic and very broad ground and I feel as Dr. Moffat does, that while those who first and who afterwards stood by antitoxin are beginning to waver, that we do not want to be coming in on the tail-end of the drive, pick it up and claim it does more than homœopathic remedies. I myself do not believe it can.

DR. A. W. PALMER: I have been very much interested in antitoxin and I feel I was quite fortunate in getting some pretty good homœopathic instruction and clinical experience in going in the children's clinic with Dr. Deschere after my graduation. While there I went through two pretty severe epidemics of diphtheria and we used exclusively the homœopathic remedies. Since that, when the antitoxin came up and was so enthusiastically advocated by the allopaths, I was loath to take it up and I didn't until rather late and I have used it very cautiously. What I want to say is this: I have studied the reports of foreign hospitals where antitoxin has been used very thoroughly through an English throat journal and I want to strongly endorse Dr. Fiske's idea or what Dr. Fiske said regarding the failures of antitoxin, that they were about proportionate to those of good homœopathic treatment as I compared them. I will try to look up the comparative statistics and report them at some future meeting.

DR. R. A. ADAMS: We are often presented with some specific, some "cure-all", and too ready to accept something, *anything* that some one or anyone tells us about as a specific for diphtheria or anything else, throwing away the history and facts demonstrated by a century of experience, thus abandoning our faith for the fad of the

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day. Now after thirty-four years of experience, after encountering many cases of diphtheria, I want to stand on record as saying that in my opinion, after mature practice and observation, that homœopathy gives us the maximum of good, the minimum of bad results in the treatment of diphtheria; gives the best statistics that any treatment has given us—except the statistics we have just listened to to-day—almost uniform results of antitoxin. I have never used antitoxin. I have not lost a case of diphtheria in more than five years, and in an experience of thirty-four years only a half dozen, but after having a few fatal cases I may, like Dr. Fiske, resort to it. I had an experience very recently. I was called a short time ago to a case that was abandoned. I was sent for and another physician who used antitoxin more than any other in Rochester was sent for at the same time. I, too, prescribed for the child, the other doctor to use antitoxin. I arrived before he did and I prescribed. Before my next call he had been to see the case but did not use the antitoxin. We talked the case over by telephone and I took the responsibility of treating the case without antitoxin, giving it lachesis. The child went on to a moderately rapid recovery. Within the last two weeks I was called to a most discouraging case in the family of another homœopathic physician in town. I prescribed for the boy and talked antitoxin with the doctor and we concurred in deferring using it for the time. That evening I had an opportunity at a meeting of our hospital staff and asked the one of all our group who had used antitoxin most what he thought of it. He said: "If it is a malignant case I would not use it." That case is now convalescent without change of remedy. Again I say, I want to stand on record, backing the fact, that homœopathy gives us the maximum of good and the minimum of bad results in the treatment of diphtheria as indeed it does in other diseases.

DR. CANDEE: This discussion is very interesting to me, as well as to probably every one present, and I apprehend that Dr. Adams has struck the keynote. We are not going to find this specific. The experiences related by the several gentlemen have impressed me as being particularly interesting. There have been times, when, as Dr. Fiske has stated, I have thought homœopathic treatment almost invaluable in the management of diphtheria, but pride has had a fall as in his instance. I have used antitoxin a number of times during the last few years. From personal experience with antitoxin up-to-date, there is a record of invariable success. Have had no failures. However, I am mindful of the experience and unfavorable criticism of those who have used it very freely. One cannot, in considering the question of antitoxin, be blind to those things. At the present time I feel like this regarding antitoxin; it is a means to be considered. I am not prepared to use it as a routine treatment of diphtheria. I should not hesitate to use it in a case that was going on unfavorably.

DR. FRAZIER: I have had some experience in treating diphtheria with antitoxin within the last four years. I must say that I have yet to meet with my first case of disappointment. The nearest to a disappointment was a case I attended the fore part of the winter which

had been sick five days before I saw it. It was of the nasal form and then of the croupous form. To that patient we gave eight thousand units in twenty-four hours before we could see much improvement. But he did improve and he got well. I think we have heard one gentleman say, they seldom use it on themselves. Here is an instance where it was used on a physician. There was an epidemic in that section and the relatives and friends kept running in spite of the doctor and the health officers. I had a good many cases on my hands and finally I decided that my throat was affected. I did not wait twenty-four hours before I used two thousand units. I was really sick, but I got better soon. In four hours I felt wonderfully relieved. In my practice the severe cases, the hard cases, never failed to get antitoxin; some mild cases do not. I never stop giving homœopathic remedies as may be indicated in every case. I am glad this matter has been brought up. I like to hear both sides of the subject. To me antitoxin has been water upon the fire and if I can only get there quick enough, it is sure to go out.

DR. GORHAM: Dr. Moffat said I stated there had never been any failures with antitoxin. I did not so state. I said there had been no bad results from the use of antitoxin, from which I meant that antitoxin would not injure the patient. The statements which I made I think can be all verified. I have the material. What is of more importance than the discussion is a few words I wish to say about the matter of using antitoxin. There may be some gentlemen who have decided that when they go home they will use antitoxin. A gentleman said that when he saw a case was not getting better he would use antitoxin. The time to use antitoxin is in the beginning and it is always sure to arrest diphtheria as is water to put out fire, if you use it early and in sufficient doses. The letter I read you from Dr. Burrows, of Boston, is pretty solid truth. There is some virtue in antitoxin. Another question was to decide whether or not it is homœopathic. If the physician has nothing better to guide him than "is it homœopathic" I am sorry, and I hope he will study and investigate the beneficial results that come from giving antitoxin, even if it is not homœopathic.

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# AN UNUSUAL FŒTAL MONSTROSITY.

GEO. R. STEARNS, M. D.,
BUFFALO.

Every physician who does any considerable amount of obstetrical work cannot but be impressed with the universality of the belief in and dread of birth-marks and monstrosities among patients and those directly connected with them.

It is like the proverbial burglar under the bed of every unprotected female, which is always looked for and the customary failure to materialize on the part of that much-dreaded individual only serves to give zest to the continued search. The first remark made or question asked by ninety-nine out of every hundred recently-delivered mothers will be: "Are you *sure*, doctor, that the child is perfect?" and it will take the combined assurance of the physician, nurse and family to convince her that the new-comer is all right until she can go all over the ground and *see* for herself.

Scarcely less marked than the universality of this belief is the rarity of the occurrence of any actual abnormality in the way of birth-marks of any considerable size, deformities or monstrosities. But the burglar does occasionally turn up, though rarely where most expected, and just so we find on fortunately infrequent occasions some form of abnormality in development which serves to keep alive the dread and fear in the lay mind. Such an occurrence is the occasion of this brief paper.

Mrs. K., 29 years of age, of fine physique, well and strong in every way, of genial, equable temperament, consulted me along in the fall with reference to her expected confinement. She had one child, a handsome, well-developed boy, between two and three years of age. Menstruation ceased after the regular flow early in May and the early months had been uneventful, there being no unusual occurrence of any kind worth mentioning, fœtal movements appearing somewhere about October first. Early in November she consulted me for a gradual lessening in the force and frequency of the movements of the child, but upon examination I found the fœtal heart beating normally and while the response was not so vigorous as it frequently will be at that stage of development, there was undoubted life there and I quieted her apprehension by a statement of that fact. Early in the morning of December eighth I was called to find her in labor, having been suffering from transient and irregular pains during the night and stating that she had felt no fœtal motion for nearly a week previously. The labor was short and comparatively easy, the result being a fœtus of apparently about six months' development and from the maculated condition of the skin on parts of the body, appearing to have been dead several days. The placenta and secundines came away clear and promptly and the mother made a rapid and in every way satisfactory recovery.

On examining the dead fœtus I found a monstrosity of, to me, quite unusual type. The deformity consisted in an apparently entire absence of the spinal column. The head was rather large proportionately and instead of curving in at the base came down almost squarely upon the chest and shoulders all around as though the base of the skull were wanting. The apparent absence of the spinal column so shortened up the trunk that the projecting portions of the crests of the ilii came just below the level of the insertion of the *ears*. The locality usually occupied by the sacrum was taken up by a soft, reddish swelling, about the size of a large horse-chestnut and in every way similar to an ordinary *spina bifida*, there being no evidence

of bony structure in that locality. On account of this same shortening of the trunk the abdomen was forced downward and forward as though the contents formed a large hernial projection the size of a small orange and reaching about half-way to the knees as it rested on the anterior and inner surface of the thighs. The anterior and lateral chest walls seemed to give evidence of preparation for bony, or at least cartilaginous development but the peculiar position of the pelvic bones just below the base of the skull left no room for costal insertions posteriorly and forced the locality of attachment of the arms to the trunk rather farther forward than normal. The development of both arms and legs seemed to be about normal, the shortened trunk allowing the hands to reach below the knees as the fœtus was held erect.

There is no evidence in the ancestral history of the parents on either side, of any abnormality of development or deformity, so far as known and there was, as stated, nothing in the early months of pregnancy to act as an apparent cause for this particular irregularity. The mother is not an easily impressionable woman and will not, I think, be especially disturbed in any subsequent pregnancy by dread of a recurrence. The absence of any unusual occurrence of sufficient importance seems to remove this case, beyond question, out of the possible range of "maternal impressions," that "bug-bear" of every expectant maternity case and relegates it to a more exact and scientific knowledge than we appear to have as yet attained in regard to the biological structure of these wonderful bodies of ours and the principles which govern their development.

# REPORT

OF THE

## BUREAU OF PÆDIATRICS.

"The Treatment of Lobar Pneumonia in Infancy," - - A. B. VAN LOON.

## THE TREATMENT OF LOBAR PNEUMONIA IN INFANCY.

A. B. VAN LOON, M. D.,
ALBANY.

My purpose in presenting a paper on a subject so trite as pneumonia is not to offer anything new or startling in the way of medical treatment but rather to emphasize the value of judicious employment of general measures as adjuvants of the indicated remedy. We are frequently consulted in cases treated with an accurately prescribed drug but with little attention paid to the general care of the patient in a particular way. It is safe to say that the pneumonic process once established, it is rare for the duration of the disease to be materially shortened. We all agree that the cause is the pneumococcus often associated with exposure to cold or following such diseases as measles or whooping cough, thereby inducing a low condition of the system. The pathology is much the same as that of the disease in adult life, as are the physical signs, although the latter are frequently not so clearly marked. The onset of the disease is not always abrupt in infancy. The temperature runs an active course of 103° to 105° with rapid respirations and corresponding pulse. But our purpose is more to call attention to the care of the patient rather than discuss the pathology. The diagnosis having been established in a given case the patient should be enveloped in a jacket made of a thin layer of cotton batting between oil muslin and cheese cloth, the cheese cloth being placed next the skin. I realize that in advocating the use of the cotton jacket I will find many who cannot agree with me. I still feel, however, that to maintain the thorax warm from without affords a sense of comfort and relief to the patient whether or not it shortens the disease or renders the symptoms less severe.

One, or at most two, attendants should care for the infant. The temperature of the room should be maintained at about 70° to 75°. The atmosphere should be frequently changed, taking care to avoid

direct exposure, and a small basin of water should be set on the stove or a steam atomizer should be used to keep the air of the room moist.

"Company should be interdicted." The body of the infant should be enveloped in a light cotton comfortable to induce moisture of the skin and the body should be sponged daily with warm bathing whiskey in children with sensitive skins, in others where no irritation appears to result from the continued warmth and moisture it is advisable to merely dry the surface every four or five hours with a warm, dry towel.

The diet should be light and nourishing. I have often supplemented the mother's milk in nursing children as in those fed on cows milk or artificial foods by the use of panopepton in doses ranging from 10m. to a drachm every three or four hours. Should water be refused, as occasionally happens, the administration of salt in small quantities will serve to create a thirst and water will be readily taken.

A movement of the bowels should be induced each day.

Regarding the use of stimulants it has been my practice to administer brandy in from five to fifteen minimum doses every three to five hours where the pulse rate reaches 140 or more. The size of the dose being regulated by the apparent necessities of the case. I rarely find it necessary to resort to the use of strychnine with children. Should the pulse continue to increase in frequency and become irregular, aromatic spirits of ammonia in five minimum doses has afforded signal relief. The respirations in my experience have afforded the best criterion as to the prognosis. When the respirations are over fifty and the cough hard and dry I have found that the inhalation of the steam from slacked lime is of much benefit, every hour or two where a steam atomizer is not available. Also the use of oxygen gas gently bubbling through water for five minutes of every hour will rejuvenate the improperly aerated blood and be of distinct benefit to the tired heart.

Regarding the medicinal treatment the drug most frequently used in this climate in the early stages of the disease is aconite in minimum doses of the $2^x$ dilution administered every hour. At the end of twenty-four or forty-eight hours the condition calling for aconite has usually passed and the second stage intervenes. Then the drug most often indicated symptomatically and also pathogenetically is bryonia in the same dilution and in the same dose.

Phosphorus has long enjoyed repute as a remedy of signal value in pneumonia, being first popularized by Wurmb of Vienna. In the stage of consolidation with pronounced bronchial breathing it is equalled by few and excelled by none. Later when resolution is taking place the older homœopaths scored their successes by the use of stibium in second decimal doses, and we perhaps can do no better than advocate the same drug. In desperate cases where the skin is cyanosed and moist and cold and the chest full of moist rales both large and small and the pulse weak, and thready, arsenite of stibium in second decimal dilution doses every two hours has often saved the day.

Sulphur is a drug which has been maligned but still proves of

value when convalescence is delayed and the vital forces do not appear equal to the task of restoring perfect health.

The use of drugs to reduce temperature can only be mentioned to be condemned. A high temperature is not alarming in pneumonia and should it seem to be assuming dangerous proportions, sponging with tepid or cold water would be the extent of my temperature-reducing measures.

Veratrum viride in minimum doses of the $1^x$ dilution every three hours has been warmly advocated by some where the pulse is rapid and the temperature high. I have seen it do good work but feel that other drugs less depressing in nature and equally sure in action are more to be recommended.

The use of serum from the blood of pneumonia patients has been used to some extent but as yet the method is in its infancy and we must wait for some further information before committing ourselves to its use.

Regarding the use of sedatives I have found that cases that are not disturbed by visitors or kind, officious friends did better than those subject to the excitement of more than the necessary help in the room. In cases where the use of a nerve sedative appears to be necessary, milk of asafœtida per rectum, though we should not forget the quieting influences of chamomilla passiflora and hyoscyamus.

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# REPORT

OF THE

## BUREAU OF LARYNGOLOGY AND RHINOLOGY.

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"Are Deformities of the Nasal Septum Less Frequent Now than Formerly," - - - - - FRED. D. LEWIS.

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## ARE DEFORMITIES OF THE NASAL SEPTUM LESS FREQUENT NOW THAN FORMERLY.

FRED. D. LEWIS, M. D.,
BUFFALO.

The above question was suggested to me by the less frequent demand now for the saw than in my early practice. In my post-graduate course the saw, drill or cutting forceps were in use almost daily and in my first years of practice, although I saw many fewer

patients, I did much more cutting. Has surgical procedure along this line become more conservative? Have we cleaned up an accumulation of cases for whom previously we had not the proper means to operate? Or are conditions such that the septi of the developing generation are growing nearer to what nature intended? I think the true answer is in the last suggestion. Now, on what basis can this belief be established? First of all let us consider what would be the most frequent cause of a septal deflection or spur. The answer is at once suggested, an injury. Now are children, during the period of development, when the tissues are soft and easily bent, less liable to injuries than they formerly were? A walk along any residence street will answer the question. In the days of years ago the children played on the streets at base ball, tag, catching rides, etc., when the nose was frequently struck, slight hæmorrhage resulted which soon stopped and was forgotten. To-day the children are sent to kindergarten at an early age and at the time when we were romping on the street they have developed into little men and women.

Another cause of deflected septum is the narrow mouth and resulting high arched palate due to adenoids. This defect has been recognized as interfering with mastication and thus with the health, and its correction is one of the great advances in dentistry. This is established by wearing a plate attached to the teeth that can be widened a little each day, gradually bringing the growing bony parts to their proper position. The great good that will result from this more normal natural position of the parts in the child cannot be estimated. The nose, as we know, is intended to take from the inspired air the solid impurities, such as particles of dust, soot, etc., and add to it moisture and heat before it reaches the lungs. This is done more effectively if the parts are as nature intended them to be. Again, deformities of the septum frequently result when there is contact with the opposite wall, in numerous and varying reflexes, oftentimes of a very annoying or dangerous nature.

It might not be out of place to refer briefly to some of the more pronounced reflexes that I have observed from this cause. The first of grave importance was in my early practice when a patient came to me stating that she had her trunks packed and was ready to start for the South to winter on account of supposed consumption. A friend of hers and a patient of mine insisted that she come to see me before leaving. Instead of sending her South I sent her to the hospital, where I relieved a pressure between the middle turbinated and septum which had been the cause of the cough that was so alarming. A week later I sent her home where she has remained since, perfectly well. The pressure in this case was from the enlargement of the middle turbinated but would have been the same if it had been a spur in the same location. Another recent case was a man who had consulted several oculists for relief of a persistent congestion of the conjunctiva of one eye, with a great deal of lacrimation. Washes and internal medication were of no assistance. The removal of a spur about the size of a bean from the nostril, corresponding to the same side as the offending eye, resulted in a speedy

return of the eye to a normal condition. The spur was interfering with the tear duct. Cases of reflex might be multiplied indefinitely but I do not wish to take the society's time for that purpose.

It is my opinion also that when there is no anterior obstruction to interfere with free respiration, there will be less tendency to the development of adenoids and hypertrophied tonsils.

These are but a few thoughts that have suggested themselves to me and scarcely make up a paper such as I would have liked to present at this time, but I hope the discussion will make up for what the paper lacks. I would like to hear from some of the members from other sections of the State if their experience coincides with mine, and are deformities of the septum less frequent, or is it a local condition or possibly simply happened so in my practice?

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## DISCUSSION.

DR. A. W. PALMER: *Fellow Members*—In this concise paper of Dr. Lewis's are several instructive points, but in opening the discussion I will speak of but three.

In answer to the doctor's question—the subject of the paper—I must admit that I have not noticed the decrease in their occurrence, at least, judging from the frequency of septal operations at the New York Ophthalmic and Manhattan Eye and Ear Hospitals and the New York Eye and Ear Infirmary.

The decrease of such operations in the doctor's practice is rather due, I think, to the increasing conservatism, caused by his close observation and individualization. The procedures employed in the early years of a physician's career are greatly influenced by the methods of his instructors and where such instruction was obtained. Whether the student was principally impressed by the rather rash and showy operator or by the conservative instructor. After a few years of actual experience the physician can and does stamp his individuality upon his practice.

The less liability of children to accident, referred to by the author and rightfully attributed to the supposedly advanced custom of sending our children to school early, instead of "romping in the street," I most heartily regret; for from my ten years' observations in the College children's clinics, as well as in subsequent private practice I believe it is absolutely necessary to have a strong, masonry-like foundation of the physical system in the child if we shall successfully erect a fine mental or financial superstructure in the man. This opinion may be substantiated if you will but once recall to mind the men of note in the professional and financial world to-day; the great majority were country boys, whose childhood was spent in the open air and in rollicksome sports instead of in the oxygenless and brain-forcing school-room. The bad effects of sundry accidents incident to rougher sports, among them those of the septum, seem

more than equaled by the generally stronger physique of the romping boy.

Respecting the "septum of the developing generation growing nearer what nature intended," although I have not personally observed evidence of such change or improvement as yet, still from all logical reasoning I believe this must ultimately result, when we ascertain how many children are now being judiciously operated upon for hypertrophy of the different adenoid tissues of the throat.

When we recall to mind that little consideration was given to the tonsils and adenoids until Dr. Hans Wilhelm Meyer, of Copenhagen, directed our attention to the deleterious effects of their hypertrophies in 1886, only fifteen years ago; when we think of this recent date we can scarcely expect to observe much salutary effect of removal of throat obstructions upon the septum.

The mention by the author of an apparent case of consumption being cured by removing the reflex cause of the cough from the nose reminds me of a case simulating the same disease cured by successful treatment of ethmoidal and antral sinusitis, which I should like to relate, but my discussion is already out of proportion to the original instructive article.

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# REPORT

OF THE

## BUREAU OF MATERIA MEDICA.

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"On a Restudy of Materia Medica," - - - THOMAS C. DUNCAN.
"Calcarea Carbonica," - - - - WALTER SANDS MILLS.
"Gelsemium," - - - - - - - L. A. MARTIN.

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Chicago, Ill., February 7, 1901.

*Dear Doctor:* Herewith find a paper that is along the line of restudy and reproving of our materia medica.

In New York was homœopathy introduced. In New York were the first specialists in our line O. and O. It would be fitting for New York physicians to initiate the movement for a restudy (which would involve a reproving) and rearrangement of the materia medica. Let the work be divided up among the specialists. Let the eye remedies be assigned to the eye men. Heart remedies to the chest specialists, etc., etc.

Dr. Bellows, in his address before the American Ophthalmological, Otological and Laryngological Society urged the reproving. Let that society take up the work for those three organs. The various State societies could encourage the work by the members of the societies willing and competent.

Hoping you will have a good meeting, I am

Yours very truly, THOMAS C. DUNCAN.

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# ON A RESTUDY OF MATERIA MEDICA.

T. C. DUNCAN, M. D., PH. D., LL. D.,
CHICAGO, ILL.

Drug study was the subject of a short paper I contributed to this venerable society one year ago. Since then the subject of reproving the drugs that make up our medical material is being urged. That is well. Let us have a restudy and rearrangement and that will necessitate a reproving to satisfy the supervising specialists.

First in order should be a better knowledge of the sequence of normal physiological functions. Do not the various organs undergo an ebb and flow in their functional activity? Are not these affected by temperament and seasons? If the prover is or was abnormal then the symptoms developed or to be developed will or should have a plus or minus emphasis.

That seems to me to be the foundation knowledge that should underlie either a restudy or reproving of drugs.

Given (1) this knowledge of the dual activity of each organ and the order of their functional activity, then we can (2) compare the symptoms of drug with the organ functions and activity and know just (3) what the drug does.

I am satisfied that each drug produces a dual action (or emphasizes the dual action of the normal organs).

Belladonna produces a dilated pupil. Is that a secondary or primary action or effect? Is there a slight contraction before or after the dilation?

Is the flushed face of bell. secondary to the dilated pupil? I know it is secondary to the bell. palpitation. What precedes the palpitation? What again is the last effect of bell.? Is it the profuse urination? Does the storm subside in that way?

I take five drops of the tincture of strophanthus and it shows my pulse; then this is followed by rapid action. The first effect is a bitter taste that causes a slight nausea, perhaps a slight shiver that slows the heart, which is followed sooner or later by the tachycardia already mentioned. Then there is a fullness in the head. I do not know how the eye or ear or throat are affected. Mental confusion follows, perhaps caused by the increased blood pressure. This illus-

trates the fact that drug restudy should be done by specialists and reproving to fill out the blank spaces made under the supervision of specialists.

We have had preaching and essay writing sufficient about our materia medica. It is time for work. Homœopathy was introduced into New York, the first specialists were educated in New York. I would suggest that this Society take the initiative of dividing the drug study among the members who are specialists; one at least to each organ in the body. There may be enough to take up two or three drugs. Let the bureau of materia medica select these, putting, perhaps, T. F. Allen in charge. One old drug like bell. and some new one, if you like. Does mercury work from without inward and sulph. vice versa? Is bell. (or atropia sulph.) a direct antidote to opium (or morph. sulph.)? How does permanganate of potash antidote opium? These are problems that this scientific study would answer. The solution of such questions would interest our materia medica or therapeutic agnostics—the skeptical allopaths. It would help the most stupid drug student to know how a drug acts. More then would know what few know to-day; the sequence of normal physiological functions. This seems to me to be the first step in either restudy or reproving. One of my first provings was made for this Society or suggested by this Society and only one symptom I verified, and that was the rectal "birds nest" of Alsculus. Who has attempted to explain that pathological fact? Have any of our orificial surgeons or therapeutists? My experience in provings since 1864 to now (to-day to verify strophanthus pulse action), satisfies me that provings are fragmentary at the best. They are often like Chinese puzzles and when the symptoms are dissected and subdivided they are to many a terra-incognita. Let us begin the century by restudying, rearranging and reproving our medical material. Let us go over the proving grounds with all our polychrests or long range guns. I think we will find that drugs produce a sequential order of effects, as Prof. Woodward, of this city, has shown us. Let New York take the initiative in this noble work and other states will follow your lead.

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# CALCAREA CARBONICA.

WALTER SANDS MILLS, M. D.,
Physician to the Metropolitan Hospital, Blackwell's Island;
Physician to the Hahnemann Hospital, Out-patient Department,
NEW YORK CITY.

CALCAREA CARBONICA of Hahnemann, the *calcarea ostrearum* of Hering, is the white portion from the middle layer of the oyster shell. Hahnemann first made provings of the acetate of lime. When he began the use of the oyster shell he thought it to be a pure car-

bonate, and so he named this preparation *calcarea carbonica*. As a matter of fact it is not a pure carbonate but contains a small proportion of the phosphate.

The various preparations of lime have been used in medicine from time immemorial. Lime water, chalk mixture, prepared chalk, are in daily use by the old school. In irritable stomachs, in nausea, and in vomiting, lime water is of great service. It is usually given with milk. The lime water is alkaline and counteracts the hyper-acidity of the gastric juice, acting as a sedative to the mucous membrane.

*Calcarea carbonica* is one of the deeper acting remedies. Hahnemann gives it in his list of anti-psorics. It has a powerful effect on the human economy and promotes constructive tissue metamorphosis. In speaking of the lime salts collectively, Bartholow says, "Entering the blood in small quantity, they promote constructive metamorphosis; but the habitual use of large quantities hastens waste, or the retrograde metamorphosis of the tissues." *Calcarea carbonica* is not very soluble in the crude state. It is, therefore, best given in potency, either as a trituration or as a dilution. I use from the sixth to the two hundredth potencies.

The symptomatology of *calcarea carbonica* is one of the most extensive in the homœopathic materia medica. In this paper, however, I propose to limit myself to a clinical consideration of the drug as it has served me in my practice.

My most frequent use of *calcarea carbonica* has been as a tissue builder. In the acute infectious diseases we usually find the digestive system upset and a loss of weight due to defective assimilation. In such cases, after the patient has become convalescent, I frequently give *calcarea carbonica* on general principles. It seems to act directly on the assimilative functions and to hasten the return to a normal condition. This use of calcarea is of special value in children. In adults it probably does better in the so-called typical calcarea patient.

There are other cases of malnutrition where the patient is run down and losing weight, but in whom more definite symptoms are lacking. The treatment of these cases is hygienic, dietetic and medicinal. The most frequently indicated remedy is *calcarea carbonica*.

In marasmus there is no other remedy that will compare with *calcarea carbonica*. I have seen some very desperate cases improve under it. The child is usually a bottle baby; it is exceedingly cross and irritable; it frequently has a cough; there is more or less vomiting and diarrhœa; the emaciation is extreme and develops rapidly. The remedy must be supplemented by a regulation of the diet. In this last, somatose is of great assistance.

There is one other form of malnutrition wherein *calcarea carbonica* is of great benefit; that is, in the condition known as lithemia. The patient may complain of headache and of various indefinite pains here and there. Examination of the urine shows it to be scant in quantity, of high color, very acid, and of high specific gravity. Under the microscope it shows uric acid crystals. In such cases I have prescribed *calcarea carbonica*$^{200}$ with excellent results.

When uric acid is precipitated in the kidneys it produces nephrolithiasis. This may consist merely of minute crystals that act as foreign bodies in the kidneys, and cause more or less backache and a general feeling of discomfort. Or, it may consist of an accumulation of crystals forming stones in the kidneys. The stones may give no trouble while being formed, but the moment they become dislodged and start on the way through the ureters they cause that excruciating agony known as renal colic. There is intense pain in the back in the region of the affected kidney, which usually extends down the ureters. In men the pain sometimes—not always—extends to the corresponding testicle. There is sensitiveness to deep pressure over the affected parts from the abdomen or from the back. There is frequently associated with these pains nausea, and occasionally vomiting. The patient in his agony breaks out in a profuse perspiration. He constantly changes his position in his efforts to find a comfortable one. Here again we find *calcarea carbonica* of great value. I use the two hundredth potency in water, a dose every five minutes until the pain stops, and then every two hours. If an acute exacerbation occurs I leave directions for the patient to take five-minute doses again until relieved. I usually have the satisfaction of seeing my patient go to sleep after two or three five-minute doses. Why *calcarea carbonica* should so promptly relieve the terrific pains of renal colic I do not know, but that it does I am certain for I have had the melancholy privilege of trying it on my own person. A search of the materia medica shows that it is homœopathic to many cases, and Hering has the following symptom marked as verified by cures in his "Guiding Symptoms":

"Gravel: urinary calculi."

I have verified this treatment of renal colic in all of my cases to date, five, and reported them at length in a paper on "*Renal Colic*" sent to the International Congress of Homœopathy at Paris. Hughes recommends *calcarea carbonica* for hepatic colic. My only trial of it was a complete failure.

*Calcarea carbonica* cured a girl of ten years suffering from chorea. She came to me at the Hahnemann Hospital the last day of May, 1900. Her illness came on somewhat suddenly about three weeks before that time when she came to me. She was constantly jerking and twisting about. The right arm and leg were almost useless, so much so that at first I thought perhaps I had a paralysis to deal with. She had always been right handed, but when she applied for treatment she had no control over the right hand. She could not write or sew, she could not even feed herself with that hand but knocked over everything she tried to grasp with it. When she walked the right arm hung limp; the right foot dragged behind. She wore off the toe and sole of the right shoe in three weeks. For six weeks she had first gelsemium, followed later by zinc. At the end of that time her condition was nearly the same and we were all getting discouraged. I then gave her *calcarea carbonica*$^{6x}$ every four hours. Improvement manifested itself almost immediately, and by October she could write, sew, or do anything that she ever did with her right

hand. August 22 she bought a new pair of shoes which were evenly worn down.

According to Raue, *calcarea carbonica* is indicated in chorea with "sometimes only one-sided involuntary motions." In this case involuntary motions occurred on both sides, but the loss of control of the voluntary muscles was decidedly greater on the right side.

In stout women of light complexion I have found *calcarea carbonica* of great use for headache accompanied by cold hands and feet.

*Calcarea carbonica* is also of service in asthma. One patient, a man aged seventy-seven, suffered almost constantly from asthma. The attacks of shortness of breath were frequent. Improvement set in at once after a dose of *calcarea carbonica.*[200] One dose each week, with plenty of sac lac in between, made him feel so much better that he felt he could get along without further treatment after a month.

The prescriber will find *calcarea carbonica* frequently indicated. A successful use of it requires a study of its symptomatology. The above, I believe, covers the clinical conditions in which the drug will be found of most service.

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## GELSEMIUM.

LYNN ARTHUR MARTIN, M. D.,
BINGHAMTON.

In presenting this remedy for your consideration I have the feeling that any one of you could probably do it better.

The frequency with which I have prescribed it of late, the uniformly good results, and its evident field of usefulness is my excuse for the attempt.

In the chills, fever, pains and discharges of grippe and catarrhal conditions, muscular lesions of the eye, neuralgia, rheumatism, eruptive fevers, congestion of brain and cord, with convulsions, rigid os, false labor pains, enuresis, post typhoid and diphtheritic paralysis it has been very useful. In the proving the prominent symptoms are from its action on the muscles of the eye, the spinal cord and the marked depression of respiration. There is weight, pressure and heaviness of the head. Brain feels as if bruised. Dullness of mind, incapacity for mental labor, sensitiveness and irritability—a sleepy delirium. Dull, dragging pain in occiput, mastoid and upper cervical region, extending to the shoulders. Sensation of band around the head. Head feels too large. Pulsation of carotids, chilliness, tongue and speech thick. Neuralgic headache, bursting pain in forehead and eyeballs, with nausea, cold sweat and cold extremities.

Ptosis, eyelids are so heavy can hardly raise them. Amaurosis, smoky appearance before the eyes with pain above them. Vertigo.

Diplopia with lateral oscillations of eyeball. Astigmatism, strabismus, dilated pupils. Eye and head symptoms caused by congestion and stasis. When the eyes are turned, the light is slow in following. Things quiver for some seconds, and the eyes are unsteady in new direction. Relieved by nux v.[3]

Irritation of nose, with tingling, sneezing and watery discharge. Heavy, dull, besotted expression of face with stiffness of muscles, hot to touch, and twitching on affected side, more often left. Paleness of face, until respiration becomes labored, after which it is flushed.

Yellowish white coating on the tongue, with numbness, so thick can hardly speak. Partial paralysis.

Tingling and cramp-like pain in the throat, spasmodic pain extending to the ears on swallowing, lump in œsophagus. Dysphagia.

Oppression and fullness of stomach, worse from pressure of the clothing. Spasmodic pain in the upper part of the abdomen. Soreness of abdominal walls. Acute catarrhal enteritis in damp weather. Diarrhœa from emotion. Tenderness in right iliac region. Stools yellow, bilious, fecal or clay colored. Sensation as of a wave from uterus to throat.

Copious discharges of clear urine, which relieve the headache. (This is a symptom I am always looking for, but have found but once.)

Incontinence, tenesmus, involuntary emissions without erection.

Severe, sharp, labor-like pains in uterine region extending to back and hips. Cramps in abdomen and legs during pregnancy. Spasmodic and neuralgic dysmenorrhœa. Inefficient labor pains, or atony. False pains. Rigid os. Palpitation of heart, frequent, soft, weak pulse, must move about to keep heart beating. (This symptom I have never been able to verify.) Pain in neck extending to head and shoulders. Congestion of spinal cord. Paraplegia. Locomotor ataxia. Trembling weakness of all limbs. Marked exhaustion. Deep-seated aching in muscles and joints, rheumatic and neuralgic pains in extremities. Fatigue and loss of power after slight exertion.

Drowsy, but cannot sleep until after midnight, with unpleasant dreams. Aching of back and limbs, exhaustion and depression, chills running up the back, coldness of hands and feet, heat of head and face. Goose flesh over whole body.

From the proving, the following generalities may be gleaned. Its action on the sensory nerves is slight and only one kind—anæsthesia—ranging from tingling of the extremities to numbness. In no case amounting to complete loss of sensation. Hence there is no true paralysis, but only diminution of sensation.

On the motor sphere the action varies from simple spasmodic movements through general weakness and slight paralysis to total loss of muscular power.

Its primary action is slightly irritant. Secondary—depressant.

Sleeplessness is more characteristic than sleepiness. The sleep that follows its use is restless and dreamful, more natural towards morning.

The drowsiness, headache and vertigo are those of cerebral hyperæmia,—passive, venous congestion with dull, heavy pain, fullness and weight.

In no part of the system are the peculiar congestive effects of gelsemium more apparent than in the eye. Besides the engorged lids we have the suffused and injected conjunctiva, due to venous stasis, similar to that caused by alcoholism.

Giddiness is an early symptom, standing or walking makes it worse, with staggering and fear of the upright position, with freedom from excitement.

Associated with this are the derangements of vision, dimness, going on to complete loss of sight, due to the over-distended vessels of the eye. The most constant symptom, and the one of greatest therapeutic value, is double vision. This symptom, with ptosis, giddiness, pain in eyeballs and brows is characteristic of gelsemium. Images in the median vertical line appear double, distant objects first undergoing duplication, one image higher than the other.

It is also homœopathic to hyperæsthesia of the bladder, whether occasioned by sexual excesses or onanism; also the excesses of old men, which are dependent upon weakness of the sphincter vesicæ, or an enervated condition of the walls of the urethra.

Aggravation—from warm coverings, after sleep, in p. m., after breakfast, walking in open air and drinking wine.

Better—by gentle motion, when erect, from pressure, after urinating—the reverse of aconite.

In aphonia or functional laryngeal weakness, or from straining the vocal cords this remedy compares with causticum.

The monograph on gelsemium, by the Hughes Club, to which I am indebted for part of this paper, states that it has little effect on the pulse or blood pressure. In my hands it has lowered the high pulse and temperature very promptly. The cases of grippe, in which I have used it early, have been very free from bronchial and laryngeal complications.

# REPORT

OF THE

## BUREAU OF OBSTETRICS.

"A Neglected Obstetrical Duty," - - - WILLIAM P. FAUST.
"A Peculiar Case," - - - - - HATTIE C. VAN BUREN.
"Sudden Rise of Temperature during Puerperality," - - EMILY F. SWETT.

## A NEGLECTED OBSTETRICAL DUTY.

WILLIAM P. FAUST, M. D.,
ALBANY.

When asked by our worthy chairman to write something for your consideration at this meeting, the thought immediately occurred to me, what can I offer to enlighten the minds of those who have long since been initiated as practitioners, passed through the school of experience and now appear among us as past masters in the science and art of obstetrics?

It is not my object at this time to enter into any new phase of the ordinary diseases and experiences attendant upon the lying-in period in so far as the mother is concerned. It is with reference to the child that this brief article shall deal. It might, therefore, be urged that we should consider the subject more appropriately under the head of pædiatrics, but in so much as the obstetrician is so often the pædiatrist as well, we think the article has a place here. Success in the lying-in room depends upon attention to little things and he whose detail and asepsis are most nearly perfect will have the easiest "row to hoe." We have articles on attention to the child's eyes, mouth, etc., but I have scanned the Transactions of this Society in vain to discover if any one had suggested to attend at once to any abnormal conditions of the male penis. The vast majority of male children are born with a phimotic condition. Very often a child is delivered, cord ligated, eyes properly cleansed and then turned over to the nurse and no more attention paid the child's genitalia than as though nature had not endowed him with such an important organ. I claim it is just as much the duty of the obstetrician to see to it that the foreskin is freely movable over the glans and if not, to make it so, as to see to the proper cleansing of the eyes. It is but the work of a few moments to correct this difficulty and if done early

—any time during the lying-in period—will be practically free from pain, save the little patient endless wear on the reflex nervous system, save the parents sleepless nights, make the organ infinitely more cleanly, to say nothing of the saving of time and money to the patient in after life by rendering liability to venereal disease much less. Less than three months ago I was called in consultation to see a child that had cried incessantly since birth. Finding nothing to account for it except a phimosis, I suggested a circumcision. My consultant replied, "What, you would make a Sheeny of him!" Such ignorance is hardly credible in this enlightened age, but as this case illustrates, it does exist. Physicians are, and of right ought to be, educators and this little point, it appears to me, has been one neglected by many practitioners.

If this article will serve to draw the attention to this matter the purpose of the writer will have been well served.

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## DISCUSSION.

DR. MOFFAT: *Mr. President*—A great deal has been said pro and con on early circumcision. As I understand the troubles arising from want of circumcision are, as a rule, adhesions between the prepuce and glans or the corona. Does anyone present believe that these adhesions exist at the time of birth, that there is any irritation at the time? I do not. They may come sooner or later. Should we make a preventive operation, or do we want to wait until the patient has sleepless nights, etc., before we operate? We haven't heard so much lately of stretching the foreskin. I do not believe in tearing up adhesions anywhere, unless we are sure they will not re-form; most operators, I fear, are not emphatic enough in their instructions or aftercare to insure that they do not re-form. I would like to ask the opinions of members of the Society whether, in their observation the baby's penis and foreskin change. My father used to teach that in a new-born boy with an apparently too long foreskin or with too small an opening in it would frequently come all right without interference. While you might not be able to retract the foreskin in the new born, after awhile you can. Has any one here had that experience? Is it safe to trust this to nature?

DR. SIDNEY F. WILCOX: I have been in practice for a number of years and wherever I attend a case where a boy is born, I follow out the Mosaic injunction and circumcise the patient on the eighth day. I do not know why the eighth day was selected, but it is a very good time. The operation is done with very little trouble and occasions very little amount of pain. It does not require any sutures and all future trouble is saved.

In regard to one or two points which Dr. Moffat brought up, I will say in almost all cases there is an adhesion between the foreskin and the glans at that time. In regard to the very small opening, that is

more apparent than real. The reason it seems so small is on account of the close adhesion of the prepuce and glans; but if you run a probe between the glans and the prepuce, you will find the opening is of normal size—that is, the smallness of the opening is more apparent than real. Operation is simply to draw down the prepuce, not too much. The great trouble is that too much skin is removed and not the mucous membrane—as small a portion of the skin as can be removed and afterwards retract carefully over the corona, while the mucous membrane should be removed freely. I do not think that the stretching of the prepuce is of the slightest use. There is a tendency to retraction at a very early period and if the mother or nurse has to be instructed, it is a constant fussing with the child and I think it is just as likely to induce bad habits in the small child as any practice that you can possibly introduce. So I believe that this circumcision of very young boys is an excellent practice and one that should be carried out as a routine.

DR. MOFFAT: I wish to ask the doctor why we can be more sure of a baby having that operation healing up without any stitches, without any cicatricial contraction, than we can in other people.

DR. SIDNEY F. WILCOX: Because the tissues in that time, the process of glueing together, occurs more rapidly the younger the child is; that with the fat over the prepuce and skin, the tissues are pressed closely together and healing takes place, the agglutination of the two edges takes place within twenty-four hours and no sutures are used. You wrap a little strip of gauze about it and fasten it by flexible collodion and you leave that on four or five days. The operation should be done aseptically and then in four or five days let the nurse set the baby in a tub and it will soak off and that is the end of the whole thing.

DR. MOFFAT: I do not think it is a simple matter to put a bandage around it. I have tried and failed and I think others have tried and failed.

DR. SIDNEY F. WILCOX:: I have done it a great many times and have not failed. I take three-quarters of an inch of iodoform gauze and wrap it carefully around three or four times and then fasten the end of it with flexible collodion. Do not put the collodion all the way around for that makes constriction. It generally stays on as long as you want.

DR. FAUST: My own method of treating these cases is as follows: after the attention to the foreskin, slitting up the dorsum, etc., I simply have the nurse apply, at intervals of every half hour or hour for the first twenty-four hours, hot fomentations of boracic acid solution and I have never had any cause to regret it. It obviates the difficulty of putting anything around the organ at all. The dressing is fastened on with a diaper.

# A PECULIAR CASE.

HATTIE C. VAN BUREN, M. D.,
BROOKLYN.

Mrs. W., aged 23. American; family history good. Personal history good until during the last two or three years she had suffered from pain, tenderness and occasional enlargement in right side of abdomen.

Menses regular and painless. Some leucorrhœa; always a "bearing-down feeling when standing," which her business of silk-weaving caused her to do all the time. For about three years she had noticed that riding in the cars always caused nausea and frequently vomiting.

She was married in May, 1900. Menses regular in June. The day before time for July period she assisted to carry a lounge down two flights of stairs, she being at upper end, hence leaning over and pulling at same time.

The following day being Sunday she and her husband went for a walk. While out she was taken with fearful cramps and flowing. They called in a doctor, who said she had had a miscarriage. He prescribed but flow did not cease; how many calls he made I do not know. This was in July. Early in August she recovered sufficiently that they came to Brooklyn to board, but she continued flowing all the time, sometimes a regular hæmorrhage, sometimes only a little. August 13th I was called. Found patient to be slight, tall, fair-haired, blue-eyed, very pale and extremely weak. There was some tenderness of right side of abdomen, which seemed slightly enlarged.

Digital examination revealed a patulous os uteri, a bad anteflexion, but apparently no abnormal growth, flow dark colored but not offensive. Manipulation caused nausea and retching. She had a bad cough, hollow and harsh; expectoration frothy and copious; chest very flat.

Patient was emaciated; no appetite; great thirst; could not sleep; seemed dull almost to stupidity, which was increased by deafness; there was no temperature; pulse slow and feeble; only 68. ℞ Bell. China.

August 14th.—Patient feeling much better; no fever; pulse weak. 75. Speculum examination revealed only an eroded, gaping os uteri. Much less flow. ℞ Remedies continued.

August 16th.—Patient sitting up; feeling decidedly better every way. ℞ Remedies continued less often.

August 18th to September 8th.—Away on vacation.

September 11.—Patient called at office; said she was "feeling real good, only weak, had not seen any flow for over a week." Abdomen was increasing in size in the center only. Made an appointment for her to call and have a careful examination to determine stage of pregnancy if such existed.

September 21.—I was hastily summoned; found patient greatly

excited. Said she "had passed an enormous mass and felt so faint afterwards." Examination of the mass revealed a partially decomposed placenta and a large quantity of coagulated, dark-colored, offensive blood. There was no temperature; pulse very weak and quick, but only 80. There was a very little flowing, no pain, some soreness over right ovary. In center of abdomen was an immense protuberance resembling an inverted two-quart bowl, hard and symmetrical. ℞ China.

September 22d.—Patient feeling better but this hard enlargement still there. Examination revealed what seemed to be a placental mass and membranes partly extruded and decidedly adherent superiorly. I explained to her it would be wiser to administer chloroform and curette. Right here let me state there were absolutely no conveniences. Poverty, ignorance and filth were rampant. I obtained assistance. Chloroform was administered without difficulty. I succeeded in detaching some placental pieces, strings of membranes, quantities of clots, but when I attempted to use a curette it slipped as if on a greased surface and did absolutely no work. Ere this I found that the uterus seemed to be divided into two sections or compartments.

Whether due to an hour-glass contraction or abnormal development I have never positively settled in my own mind. In the upper section there seemed to be lodged another mass, but of different consistency; while debating as to method of removal there occurred a rupture of a membrane or sac and immediately there poured forth a gelatinous mass like frogs-spume, and simultaneously the enlargement of abdomen decreased.

By persistent manipulation I removed about a quart of this mucocolloid substance, and finally I detached a sac or membrane as you would a placenta. I used a plain hot douche and washed out quantities of this substance; then a two quart douche in which I put one-half ounce of Wampole's antiseptic solution, followed by a small plain douche. Every time she coughed or retched there would pass a quantity of this peculiar substance. It seemed impossible to remove it. At the same time the enlargement of the abdomen was rapidly disappearing.

In examining the uterus there was still plainly to be felt that bridge-like band separating the body of uterus into two sections or compartments. Despite the fact that there was absolutely no nursing in this case, she being many hours alone every day, she made a very fine recovery. Once I was summoned because of a chill and high fever but found she had been fed two plates of rich soup. Nature fortunately rebelled. Again, due to worry and neglect, she had a bad spell, high fever and headache, but this quickly yielded to a few doses of ignatia.

September 28th.—Dismissed the case.

October 31st.—She called at office; she said she was perfectly well, doing her own housework.

What was that gelatinous substance, and from whence did it come? Had she had ovaritis and was this the product of inflammation?

Was it retained in uterus because of its malformation or because of attachment of placenta in lower segment of uterus? She had been flowing more or less constantly from July 7th until September 22d and still there was a large placenta. When did she lose the fœtus? Was there any or was it a false conception?

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## DISCUSSION.

DR. DEWITT G. WILCOX: Referring to the former paper just read, "A Peculiar Case," I think it is entirely a question of mole pregnancy complicated with uterine fibroid. Where the uterine walls undergo degeneration and pregnancy continues to delivery, there is an arrest of circulation through the uterus, so that the ovum mav develop for a period and then cease; but that does not interfere with the development of the placenta. That will go on and perhaps even over-develop, because it is not supporting the fœtus. It will go on to a certain extent and then be delivered. As it cannot be delivered naturally, that is, intact, because of the interference to natural uterine contraction, due to fibroid degeneration, it must of necessity come away in piece meal, as in this case.

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# SUDDEN RISE OF TEMPERATURE DURING PUERPERALITY.

EMILY F. SWETT, M. D.,
MEDINA.

The period of puerperality or the time from the birth of the child until the woman is up again, a period from twenty to sixty days, is one of much interest, and not infrequently of great anxiety to the attending physician. The severe mental and physical strain which have ushered in the little new life are over, but the end is not yet. The prolonged chill which so often follows delivery must be watched lest it become pathological. The slowing pulse-rate, peculiar to the lying-in woman (in whom we sometimes meet six or eight hours after delivery the slowest pulse under any condition in health, thirty or forty per minute) tells us that all is well, provided the pulse and temperature correspond. Low temperature, 96° or 97°, with a rapid pulse warns us of hæmorrhage, while the full, bounding, strong pulse calls our attention to cerebral disturbances and possible convulsions.

The period of reaction safely past and lactation established, our patient is still not free from the possibility of septic infection for

several days to come. The initial chill rarely repeated, the hot skin, high temperature, insatiable thirst, dry throat and mouth, mental excitement and wakefulness, form a picture and suggest possibilities which are not pleasant to contemplate. I wish to cite a single case of sudden high temperature during puerperality.

Mrs. D. was delivered December 2nd of a male child, after a normal and not particularly tedious labor. Her first child, born two years previously, after a most severe and prolonged labor, had died soon after birth.

No abnormal symptoms developed and lactation was established the third day. When I called, the fourth day, I found her with flushed face, dilated pupils, rapid breathing, twitching about the mouth and eyes and a pulse of 160. She was excited, and seemed like one on the verge of a convulsion. I was assured both by the nurse and herself that there had been no chill nor even chilliness. As I placed the thermometer in the axilla, the skin seemed scorching hot like that of a scarlatina case. In removing the thermometer the bulb of mercury fell off, and I was surprised and alarmed at finding it registered at the extreme limit—110°. My search for hot water bottles or poultices in the bed was in vain.

With the least possible loss of time I put one teaspoonful of gelsemium θ into two ounces of water and gave her one teaspoonful every five minutes until all was taken. The second quantity was prepared in a like manner and given every ten minutes for one hour. Then I left her long enough to secure another thermometer. This time it registered 108°. In another hour it fell to 106° and she began to perspire. Gelsemium was continued at lengthened intervals for thirty hours, at the end of which time the temperature had reached the normal point.

The closest scrutiny and inquiry failed to reveal any physical cause for this temperature freak. I ascertained, however, that in his great joy over his first son, the father had been "making merry with his friends" and had come home in a condition new to his wife.

The possibility of a septic condition which the gelsemium promptly and effectually controlled is admitted, but I am firmly of the opinion that the shock and surprise and chagrin caused by her husband's condition was responsible for it. This opinion is confirmed by another case, similar in every respect, except that the temperature did not rise above 107°.

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## DISCUSSION.

DR. BUTLER: I would like to make a few remarks on the last paper. It seems to me it is fever. I think it is very uncommon to have such a temperature as that. But we should congratulate ourselves for having such a literature and homœopathically to stick to that remedy and not give the coal-tar remedies.

DR. MOFFAT: Whether the indications given in that case were for gelsemium or aconite, is so much gelsemium good for the patient?

DR. BUTLER: I think she would have done just as well as if she had had no medicine. The fever would have gone down itself.

DR. ADAMS: I want to ask if any one thinks for a moment that the doctor concluded that this was a case of septicæmia and whether that temperature would have gone down or whether she would have gone down to a cold corpse.

DR. BUTLER: I think the chances would have been for a cold corpse.

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# REPORT

OF THE

## BUREAU OF NEUROLOGY.

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"The Seventh Cranial Nerve," - - - - P. W. NEEFUS.
"Is There a Distinctively Homœopathic Therapia in the Treatment of Mental Diseases?" - - - J. T. GREENLEAF.

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## THE SEVENTH CRANIAL NERVE.

P. WYCKOFF NEEFUS, M. D.,
ROCHESTER.

The burden of my paper will be that form of facial paralysis representing the infra-nuclear type.

Our first inquiry will be, how to recognize this form from nuclear or supra-nuclear origin. Let us place before our mind's eye a patient suffering unilateral facial palsy and you will notice the entire half of the face is involved in a fixed expression. Voluntary or emotional movement is no more. From the brow to the chin the surface is smooth and in a relaxed state; the eye remains open; the naso-labial fold is obliterated and the corner of the mouth is materially lowered. Pain may or may not be a factor.

Upon the unaffected side we see an overaction of the unopposed muscles. Given such a case you can safely assert no damage has occurred to the central nervous system. In central lesions of the pons or cerebrum, remember we have only the lower portions of the face affected, and then usually with some associate paralysis, as nerve fibres to other parts of the body are in close relationship with those

of the seventh. Should any doubt exist, an electrical examination will decide. Should the lesion be supra-nuclear, reaction of degeneration will be wanting, which we will endeavor to explain later.

The position of the seventh nerve rather invites trouble than otherwise by its anatomical position, and no nerve is so liable to independent paralysis.

We find it in an unyielding bony canal for a considerable distance (aqueduct of Fallopius) coursing through the petrous portion of the temporal bone, from the internal auditory meatus within, to the stylo-mastoid foramen on the outside of the cranium.

Neuritis, the result of debility or exposure to cold, is the most common cause of trouble. With the consequent swelling of the nerve within the unyielding bony canal, you can readily conceive the affect to be pressure of different degrees, *according* to the amount of *inflammation* and swelling. Nerves are not organized to withstand pressure, and a happy termination of your case is not as promising as when the lesion is outside of the stylo-mastoid foramen.

Look also to the reflex movement of the lids. In infra-nuclear palsy the reflex is lost. In the supra-nuclear type the reflex is intact. In the former you will find it possible to even touch the eyeball and although the sense of touch remains normal, you get no response from the orbicularis palpebrarum.

Fortunately in such cases we have an excessive flow of tears, *protecting*, in a great degree, the *eyeball* from injury. Even at the best, the eye often becomes inflamed, and it is advisable to frequently bring the lids together by means of the *fingers*, so as to protect the eye from particles of dust and the like. In fact, such patients should *stay* at *home*, but if necessary to be *out*, the affected side should be protected, particularly during the full time of the active stage.

Remember that in *all* forms of neuritis, *rest* is of the *greatest importance*, and does much to assure you successful treatment.

Suppose, now, we ask our patient to protrude his tongue. We say "his" because the male is more liable to this disease than the female, owing, doubtless, to the greater amount of exposure.

Upon first appearance, the tongue seems to deviate towards the sound side, but upon closer inspection this condition is not found to actually exist, such appearance arising from the fact that the lips are uneven by the contraction of the sound side and relaxation of the affected side. This point, unless taken into consideration, might lead you to an incorrect diagnosis.

Now, keep the tongue out and test for taste, which we will see assists in localizing the lesion.

We will suppose in our case, we find by applying a little vinegar, loss of taste upon the anterior two-thirds of the affected side. Clearly the nerve of taste, the chorda tympani, is involved, which gives us an *associated paralysis*, and we can therefore, with certainty, locate the lesion within the bony canal, because the *chorda* leaves the seventh nerve within the temporal bone.

Another point relating to localization: There is a branch given off to supply the stapedius muscle, so if hearing is affected (sensibility

and sounds being increased) it places the lesion *above* the point where the chorda joins it. At times you will find both taste and hearing affected, in which case the lesion will be at the middle of the aqueduct of Fallopius, and you will have a different case to deal with. Naturally enough, the nearer the lesion is to the central organs, the greater is the danger to your patient, and it is well to keep these points of localization in mind, so as to properly guard your prognosis.

Lastly, with taste and hearing unmolested, the lesion will be in the neighborhood, or external to the stylo-mastoid foramen.

Disease of the middle ear will at times cause facial paralysis but then you have guiding symptoms prior to the paralysis. Fracture of the temporal bone and inflammation of the parotid are also causes. Often, however, without ear disease you find discomfort and even a slight swelling in front of the ear.

The amount of pain *varies* in *proportion* to the *inflammation* and *swelling* within the bony canal. So also the destruction of the nerve varies in proportion to the inflammation and *pressure*. Necessarily the greater the destruction, the greater will be the *subsequent atrophy* and *contraction*, providing your case goes on to recovery. Of course, if recovery does not occur, the contraction will be wanting and the parts will remain relaxed. You must expect, even in all successful cases, eventually to have a certain degree of contraction, some twitchings, and a *smaller eye*. It is advisable to guard your prognosis. The condition may last a few weeks, a few months, or remain an eyesore not only to you, but more especially to your patient.

If it becomes essential to know as positively as you can know, an electrical examination will give you the best and surest information. It is on record "if at the end of ten days the *irritability* of the nerve is not *below normal*, the face will probably be well in a few weeks. If, on the other hand, at the end of a fortnight the irritability of the nerve *is absolutely* lost, the paralysis will certainly last for several months. If, at the end of a fortnight the nerve irritability, although lowered is not lost, recovery will probably occur in about two months."

Let me, in a few words, state some points relating to the electrical reaction. Applying the faradic current to a healthy muscle, contraction results, but in infra-nuclear palsy it is lost. Now, take a constant current from your galvanic battery, and you will find the *reverse* stands out very prominently. The paralyzed muscles are more sensitive than healthy muscles. The former responding to a current *too weak* to *influence* the *healthy muscle*. This test is made with the positive pole at some indifferent point, and the negative applied to the paralyzed muscle.

Remember that sensation is not lost, and be careful not to give any greater discomfort to your patient than possible by a strong current. This test pertains to all peripheral paralysis, which is a strong diagnostic point in separating such lesions from those of central origin. You must bear in mind the fact that the nutrition of peripheral nerves is controled by its nucleus—supra-nuclear fibres by the cells in the cerebral cortex. Consequently, in supra-nuclear lesions the peri-

pheral fibre is still supported by its nucleus and the power to respond properly under an electrical stimulus remains. Whereas, if the lesion destroys the nucleus or affects the conducting power of the nerve, nutrition is cut off, degeneration follows, and your faradic current ceases to act. The nucleus of the seventh is in close relationship with other cranial nerves, particularly the sixth. The fibres after leaving the nucleus, pass backward and encircle the sixth, some fibres passing through the latter.

Before we pass to the treatment I want to add that *gout* and *syphilis* are frequent factors in the cause of the trouble under discussion. Often you may find syphilis the predisposing, and exposure, the exciting cause. Important sometimes in directing your treatment.

What shall we say regarding treatment?

Paramount to all other advice, I would urge you to give the *homœopathically indicated remedy!* Most frequently it will be found, for the *active stage*, in *aconite*, *veratrum viride* or *gelsemium*. Later, *causticum*, which you will find not only adapted to the paralysis, but also to the tendency to *tension* and *shortening* (contraction) of the muscles.

*Baryta carb.* will yield good results in scrofulous subjects. Under the domain of this remedy, you will also find contractions.

For auxiliary treatment in the active stage you will get great assistance from hot fomentations. Have two flannel pads made, five or six thicknesses, about as large as two hands. Have them quilted sufficiently to keep them in form. Dip one in boiling water and pass through a wringer, shake the steam out and apply as hot as the patient can endure it, then *more* than cover with one or two thicknesses of dry flannel. In five minutes remove, and immediately apply a second pad in the same manner. Make in all, at each treatment, three or four changes, then dry and cover with dry flannel. Repeat two or three times a day, according to severity of the case, keeping in mind the sooner the inflammatory stage is arrested, the less damage will result and therefore a better chance for a cure be obtained. Keep your patient quiet when possible.

After the active stage use light massage daily, thereby maintaining better nutrition of the parts. Too often electricity is used unadvisedly. In the minds of many, paralysis always calls for the battery. I believe you might underscore: "*Never use it during the active stage.*" If you cannot give up your electricity, by all means avoid faradism, and use the voltaic current very mildly.

In the chronic stage your galvanism is of benefit in keeping the muscles in good form and to have them ready to respond when the nerve regains its power of conduction. In all cases that respond to the faradic current, it is safe to exclude electricity from the treatment, otherwise you will produce a greater amount of contraction than without such measures.

Remember that treatment from an electrical standpoint, mild galvanism with slow interruptions, is the only current to consider, and this is not to be administered during the early stage of the disease. Do not think it necessary to cause visible contractions of the muscles.

# IS THERE A DISTINCTIVELY HOMŒOPATHIC THERAPIA IN THE TREATMENT OF MENTAL DISEASES?

J. T. GREENLEAF, M. D.,
OWEGO.

To one who is at all familiar with current medical literature there is evidence of a spirit in the old school which is constantly endeavoring to show that the practice of the two schools does not differ to any extent. Until very lately the writings of the adherents of the homœopathic school have not been affected by this spirit, but it seems to be showing itself more and more as time passes.

To the writer of this paper there seems to be at least one branch of medical science wherein there is a decided difference. In the therapeutics of mental disease there is a wide diversion to say the least. So far as he can glean from the modern books on mental disease, there is no attempt to differentiate in the medical treatment of cases of melancholia. In the hands of the old school, sedatives and tonics form the armamentarium in these cases and the expectant method seems to send many cases home recovered.

As for homœopathic therapeutics in melancholia, we find veratrum album curative in most cases that have a religious turn to the delusions, for those who pray a great deal. One case of melancholia with stupor yielded to lycopodium, when it was discovered that the general symptoms indicated that drug.

One would think that pulsatilla, with its peculiar lachrymose condition, would reach many cases, but it must be said that it has proved to be very inert.

In melancholia, with suicidal tendencies, we would expect to get beautiful effect from aurum, but unless it is exhibited as a double bromide with arsenicum, it has been a disappointment.

Anacardium has proved a saviour in cases of seeming primary dementia. One of the most sodden, stupid cases of melancholia from masturbation was cured by china, persistently employed. One case of melancholia with delusions of crime and disgrace, caused by fright, was started on the road to health by aconite. Cases of apparent dementia, and some of melancholia with stupor have yielded to carbolic acid, in our hands within the two years last past.

Not long ago a case bearing all the marks of general paresis, and diagnosed as such by gentlemen of ability and experience, was entirely cleared up by thuja, exhibited because the general condition of the skin, a badly inflamed thumb and various lesions elsewhere seemed to indicate that remedy.

Another case that presented the symptoms of general paresis, was so much benefited by the double bromide of arsenic and gold, that when he passed from our hands to a state institution, his case was

diagnosed acute mania. He was treated there for five or six months and went home apparently cured, to die of dementia in about one year.

The accepted treatment for mania is to put the brain in "splints" by the use of narcotics and then to use active tonics.

Belladonna, stramonium, hyoscyamus and even coffea in attenuated doses, have served to cure many such cases, without either sulphonal, trional, chloral or other crude sedatives.

In the treatment of that medical mystery, epilepsy, the dominant school has finally decided that the bromide of potash is the only remedy for both cure and palliation and that it must be exhibited in constantly increasing quantity till the patient is stupified thereby for weeks at a time. Quite frequently the seizures are entirely checked by this method, but mental activity is also inhibited and only a few very vigorous constitutions ever recover any mental life thereafter. Unfortunately those who do so revive are again attacked by convulsions.

As a middle course between this heroic method and homœopathic medication, other bromides have been used, the bromide of strontium being as efficient as any one, but these drugs generally are inadequate to a cure.

In oenanthe crocata we have a much better and safer palliative, but suffice it to say that it has proved a palliative only in the writer's hands.

The time to prescribe, and to get the whole symptomatology of the case is between the seizures. Working on this plan there have been complete cures made with gelsemium, with nux vomica, with silicea and with sulphur.

Of course, remedies are useless in this protean malady when the cause is still active, and many cases have been entirely cured by a little orificial surgery, or the fitting and wearing of a proper glass.

If the foregoing is correct, there is no need for abandoning the law of similia in the worst cases of nervous and mental disease.

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## DISCUSSION.

DR. BUTLER: I am very glad to hear this paper of Dr. Greenleaf's and I should say, after twenty-seven years of work in this line, that there is a positive homœopathic therapia for mental disease. I should mention several other remedies that the doctor has not spoken of and one of the remedies is for chronic mania. In some of the most hopeless, apparently incurable cases, with beginning loss of memory I have made some of the finest cures with anacardium (30th, 200th), and sometimes the lower potencies, and in epilepsy—cuprum and hyoscyanic acid; silicea and calcarea carbonica. I was called to a case that had many symptoms looking to meningitis. This patient, a woman, had one persistent delusion,—that there was a double personality every night. She would have a pain in her leg and she would have a special nurse to take care of that leg. She did not speak

to her own nurse, because she feared that the other nurse would leave. She did, however, speak to her own nurse and then the other nurse became offended and left. In the day time she would speak in a perfectly sensible manner. I gave her the 200th of petroleum and removed it at once. I never prescribed it before but once. I prescribed it for delirium tremens. The patient said that he would not go to bed because there was another fellow in the bed. I gave 200th of petroleum and it removed the symptom at once. Pulsatilla has a symptom similar to it. In regard to aurum, I think it is absolutely useless. I never saw aurum do a particle of good. I have given it many times and never saw it ameliorate a case of melancholia; but in suicidal melancholia and in the run-down, anæmic and restless, those aggravated cases of melancholia, there is no remedy like arsenic. I have seen many cases cured with that. I think some of the best indications of the truth of our law of *similia similibus* can be seen by the presentation of the drugs through the well defined prominent mental symptoms. If you have a patient that has a delusion of poison, that is hyoscyamus. Stramonium, mistaken personality. One man took me for Bishop Potter, for instance. Stramonium removes that invariably. But the trouble is that it is given when it is not indicated. Stramonium is belladonna intensified. I was at Middletown a long time before I ever saw it do a particle of good, because I never saw a stramonium case. You get a case of mania, where the mania is of the very worst form, where the patient has acute delirious mania and stramonium will work like a charm, but for an ordinary case of mania it will not do any good. There is another remedy for melancholia with stupor and that is baptisia in the lower potencies. There is another thing that I have seen demonstrated many and many a time; that is the difference in the action of remedies according to the potencies you give. You take belladonna, where you have a case of passive congestion of the brain or melancholia brought on by a passive congestion of the brain; you want to give a low potency. Where you have a hyperæsthetic condition of the brain, as in acute mania, or where the violent symptoms are intensified, you want to give a high potency; the two hundredth or thirtieth will remove these symptoms. Whatever we may say about homœopathy, in the treatment of mental diseases we can claim that we are on a good, sound basis. Middletown has been running since 1874 and they have never used an opiate and they have cured hundreds of patients. I can understand why they can do there what a general practitioner or specialist outside cannot do, because the outside practitioner has not absolute control of his patients. One must give an opiate sometimes because friends of the patient drive one to it. You will have to or they will drive you out of the case or send the patient to an allopathic institution. Sometimes the doctors in general practice give opiates when if they could have their own way they would not have the slightest need of them. It is not because our remedies cannot cure, because they can.

DR. GREENLEAF: To substantiate in a word what we have said about the double bromides, a great many cases that did not yield

to arsenic did yield to arsenauro or bromide of gold and arsenic. I do not like the mixture of the drugs, but there is something like that combination that is very efficient; apropos of that, at first I had used Charles Parmale's arsenauro. I went to our pharmacist and asked why he did not make a preparation of arsenic. At last Parke-Davis have made a preparation which has been very effective and almost identical with the Parmale preparation.

DR. BUTLER: I would like to say something about arsenauro. It is a dangerous remedy. I had a case that came into my hands last year, the daughter of one of the most prominent men of the city. An eminent allopathic surgeon, something like two years before, recommended that girl to take fifteen drops four times a day. She was given that for eighteen months; and then another allopathic doctor—the first was in the army at the time—took charge of the case and said that there was no trouble with this girl's kidneys; she simply had neurasthenia. They called in an old school specialist and he said that if she did not have any trouble with her kidneys she had neurasthenia. The father of this girl called me in consultation and he quietly called in another Dr. William Butler, who was an allopath. The father then sent for me and I took charge of her case. I sent over some of her urine to Dr. Louis Heitzman and Dr. Heitzman pronounced it a chronic case of interstitial nephritis. I said, "What caused that?" He said, "Arsenauro." The girl died of chronic interstitial nephritis, and this Dr. Heitzman said it was caused by arsenauro.

# REPORT

OF THE

## BUREAU OF GYNÆCOLOGY.

"Diseases of the Right Ovary and Tube and their Relation to Chronic Appendicitis," - - - - - W. LOUIS HARTMAN.
"Appendicitis with Abscess Complicated by Ovarian Cyst —Operation—Recovery," - - - - - EDWARD G. COX.
"Leucorrhœa—Its Diagnostic Value and Homœopathic Treatment," - - - - - - - H. D. COCHRANE.
"Should Catharsis Precede Laparotomy?" - - GEO. W. ROBERTS.

## DISEASES OF THE RIGHT OVARY AND TUBE AND THEIR RELATION TO CHRONIC APPENDICITIS.

W. LOUIS HARTMAN, M. D.,
SYRACUSE.

I presume when the members of this Society unfolded their programmes and saw I was going to write on "Appendicitis," they were more weary than after the first week of professional labors, when the grippe season was in full progress, and the small-pox scare had spread over the entire country, when every person they met asked them, "Is it necessary for me to be vaccinated?" But allow me to say this subject is a very important one just the same, if when there is a paper written it takes the entire day to discuss it, especially on the subject of appendicitis.

Of course, it is generally understood that appendicitis is more prevalent in the male than in the female. This is very easily explained when the anatomical relations are taken into consideration. In the male we have only about one-half the blood supply to the appendix that we have in the female, therefore, the latter is less liable to inflammatory conditions and to put itself in a necrotic state. The vascular supply in the appendix of the male is the appendicular artery, whereas in the female we have, in connection with this artery, the blood supply coming from the appendiculo-ovarian ligament. Thus the appendix in the female having the auxiliary blood supply,

the appendicular artery is not as well developed as in the male, so you can readily see that in case the appendiculo-ovarian ligament becomes impaired, as it does in diseases of the right ovary, it is impossible for the appendix, under such circumstances, to withstand as much as that of the male.

In cases where you find chronic appendicular conditions existing, you will usually find the right ovary and tube involved. There will be a cystic degeneration of the ovary with a chronically enlarged and inflamed fallopian tube. Very often it is difficult to diagnose chronic appendicele trouble in the female, as the pain may not be referred to McBurney's point at all, or very little. These cases, however, will suffer more acutely during the menstrual period. The pains in these conditions are not like those of ovarian dysmenorrhœa. I mean by that there will not be that dull, heavy pain preceding the flow, but it will be more of a lancinating character, usually beginning immediately before or at the time the flow begins. This may not accompany each menstruation, it may depend somewhat on the condition of the digestive tract.

There are two or three symptoms which should lead one to investigate. One is the crampy-like pains between menstruations, caused by taking cold or intestinal indigestion, the latter of which is almost constant. You will find your patient unable to digest starchy foods; there will be trouble with excessive flatulence. Patients will complain that at times they become so bloated it is impossible for them to get their clothes around them. This is an uncomfortable feeling, but they are not liable to complain of pain; still when you come to make deep pressure, you will find a soreness in the appendicular region, and at the same time the sharp pain complained of will be referred to an entirly different part of the abdomen. I have several cases I will report at this time which had been existing anywhere from two to four years with this condition, where the ovaries were supposed to be the primary cause and real offenders. Now, where there has been an attack of appendicitis in the female, we are quite liable to have ovarian, or more particularly, tubular trouble following.

My observation has been in the last year that the appendices in the female are longer than in the male. In cases of chronic appendicitis the pain will be referred, as a usual thing, to the distal end; therefore, it may be in the pelvic cavity, or it may be up under the liver, usually referred to the right. In two or three cases of fulminating attacks where there has been a chronic history, the pain has not been referred to McBurney's point as much as down at the brim of the pelvis, either right or left. The following cases will illustrate:

Miss B., aged 19, college girl, had complained for about two years of painful menstruation, referred to the right side with lancinating pains radiating over the whole abdomen between menstruations. Never complained of soreness in McBurney's point, but had indigestion more or less when she was not particular with her diet. This indigestion assumed the intestinal form, and the principal symptom was flatulency. On Friday morning she was taken with slight pain in the left side, not so severe, however, as to prevent her attend-

ing school. In the afternoon the pain became more severe. On Wednesday and Thursday she had what she called her menstrual pains which usually preceded the flow. I was called in consultation with Dr. Albertson, of Oswego, the attending physician, on the Sunday morning following. Found patient with pulse of one hundred and thirty, drawn expression, flabby tongue with imprints of teeth, temperature one hundred. Upon examining the abdomen there seemed to be very little tenderness over McBurney's point, but about one-half inch above and an inch to the right of the middle of Poupart's ligament, there was an extremely sensitive point, and dullness running towards the right parietes. I confirmed the doctor's diagnosis, that of appendicitis of the fulminating variety, and advised immediate operation. The patient being prepared, anæsthetized and placed on the table, the abdomen opened and a large abscess discovered, pus liberated, abscess drained; patient made an uneventful recovery.

Miss H. W., aged 22, was referred to me for enlarged lymphatics of the neck. In obtaining her history she told me of a menstrual trouble she had had for about four years, not constant, however. Sometimes the flow would appear without pain, then again there would be excruciating pain in the right ovarian region. She also complained of indigestion which caused excessive flatulency, so much so that at times she was unable to get her clothes around her. She had complained all this time of pains radiating occasionally through the whole abdomen, but referred more particularly to the right ovary. Sent her to the hospital, prepared her for operation on the neck, and told her I would at the same time make an examination of the ovaries and uterus. Upon examination I found an enlarged ovary and tube. Twenty-four hours after the operation on the neck she was taken with what she called her cramps of the stomach, but I immediately made diagnosis of appendicitis. She became better in twenty-four hours time, but there was still soreness in this region. I advised operation for appendicitis. Upon opening the abdomen I found the appendix lying down with right ovary degenerated and inflammation of the tube. This patient had been unable for three years to eat starchy foods, but within ten days following the operation she could eat anything with impunity.

Miss A. W., of Northwood, Iowa, aged 20, had been in good health up to four years ago, when she was taken with what was called by her physician, "cramps of the stomach," which lasted about forty-eight hours. There seemed to be no localized tenderness at the time, but from that day on she had intestinal indigestion. Menstrual flow increased and was irregular. At times it would be very painful, and then again she would go through with very little pain. This pain was of the same character, radiating over the whole abdomen; would usually cease two or three days after menstruation would stop. There were nausea and vomiting. Occasionally she would have these pains between periods. She was unable to digest starchy foods, and complained of excessive flatulency. Very little tenderness over McBurney's point, but tenderness about two inches lower

down. By manual examination of the right side revealed an ovary about three times its normal size and enlarged tube, both of which were very sensitive to touch. My diagnosis was cystic degeneration of the ovary, with salpingitis, also chronic appendicitis, and I advised operation. She was sent to the hospital, where I opened the abdomen and found my diagnosis was correct, the appendix being over seven inches long, was hanging downwards and densely adhered by old adhesions. The patient made an uneventful recovery and up to this time, which is some eight months, she has been in perfect health.

If time would permit I could cite a great many similar cases which have come under my observation within the last two years. Now, the first point I wish to make in this paper is, the importance of making a thorough physical examination when we have patients suffering with what seems to be ovarian pain; second, the danger of allowing these cases to go undiagnosed. We do not do our duty when patients consult us with a chain of symptoms like above cases, until we make a thorough physical examination, for these cases are chronic, recurrent appendicitis; and we all know how such conditions are dangerous, and are liable to have a fulminating attack at any time, and be at death's door before we are aware it is coming on. Third, where this condition exists together with ovarian and tubular troubles, there is absolutely no cure without an operation. If in these cases you do not get pus, you get another condition which is nearly as bad, chronic invalidism, neurasthenia, etc. It behooves one to watch these cases carefully, as the symptoms of salpingo-oophoritis are so nearly allied to those where the appendix is complicating the trouble. There are points of difference, however. The pain in the salpingo-oophoritis is principally referred to one or the other ovarian region, the left more often than the right, and instead of the pain being sharp and lancinating, it is usually a dull, steady, aching pain. Sometimes both varieties are present, but they do not radiate throughout the abdomen, but are confined to the pelvic cavity, which is aggravated by defecation, pain lasting an hour or two after the act. We must not allow ourselves to become confused by the nausea and vomiting, flatulency and constipation, because they may exist in both.

Physical examination will reveal more and be a greater aid to a differential diagnosis than anything else; in fact, it is the only thing of which I know whereby we may differentiate, and even then it is often hard to be positive. Where the appendix is involved the pain is liable to come on between menstruations as well as at the time, otherwise only at the menstrual periods which assumes about the same character throughout the flow.

It has been my purpose more particularly to call this to your attention, than to give a clean-cut differential diagnosis, which is next to impossible.

# APPENDICITIS WITH ABSCESS COMPLICATED BY OVARIAN CYST.—OPERATION.—RECOVERY.

EDWARD G. COX, M. D.,
ALBANY.

My reason for presenting the following case of appendicitis associated with par-ovarian cyst is that it may be as interesting to the members of the Society as it has been to me.

We so often see cases of dysmenorrhœa with localized pain in the iliac fossa that it is frequently perplexing at the first examination to exclude a mild inflammation around the appendix as a complication.

In July, 1899, was called by Dr. Griffeth, of Troy, in consultation to see Miss D., 36 years old. Found patient suffering severe pain in the iliac fossa with dullness and boardlike hardness of the abdominal wall; no tumor could be felt. The temperature was 100 3-5, pulse 92. Made diagnosis of acute catarrhal appendicitis and advised the use of olive oil in ounce doses every three hours per os, bryonia third dilution every hour and hot flaxseed poultices to the abdomen. Saw patient following day and there was no change in her condition, no nausea and very little pain. Advised her attending physician to observe symptoms closely and to notify me of any sudden rise of temperature or of rigors and expressed the opinion that the attack would pass off quietly and that an operation could be performed more advantageously after recovery from the acute attack.

At 3 o'clock in the afternoon of the fourth day was notified that the patient's temperature was 102, pulse rapid and a well defined tumor could be distinctly felt in right iliac fossa. Immediately prepared for operation.

On opening the abdominal cavity over the mass I first encountered a fluctuating tumor which was opened and about a half a pint of brownish fluid withdrawn. On passing the finger down into the cavity from which the fluid was taken I punctured through into a pocket of pus holding about two ounces. Apparently the adjacent pus focus had caused an inflammation in the cyst wall inducing degeneration of the cyst. The appendix was found completely wrapped in adhesions and attached to the cyst which extended from the broad ligament. I supposed it to be par-ovarian, but owing to shortness of the incision it could not be seen. As the surroundings were very unfavorable to extensive manipulation of the intestines and as the abscess cavity appeared to be thoroughly walled off by fairly firm adhesions I decided to drain. After carefully washing out the cavity with sterilized water, a glass drainage tube was inserted in the region of abscess and the incision partly closed. The patient's temperature the evening of the day of operation had fallen to 100; the following morning it reached 99½ and never went higher. The glass drainage

tube was removed on the third day and the whole cavity loosely packed with iodoform gauze. The gauze was gradually removed, so that at the end of the second week the incision was practically healed and on the 21st day the patient was up and around and has since enjoyed good health. I am firmly of the belief that had I resorted to a prolonged dissection to remove the cyst wall I would have caused a general peritonitis, which would have resulted fatally to my patient.

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## DISCUSSION.

DR. DEWITT G. WILCOX: In reference to this paper and the one just read, I have my doubts as to whether an appendicitis causes oophoritis and salpingitis, but I do believe that salpingitis will cause appendicitis. My reason for this is, that we know when salpingitis exists the inflammation comes in the lining membrane of the tube and immediately after that inflammation the fimbriated extremity becomes sealed and pus goes on and collects. If pus exudes from the fimbriated extremity it will cause a general inflammation of the pelvis. If the appendix happens, however, to be in the pelvis, it must partake of this general inflammation and we get appendicitis as a result with attachments and adhesions of the appendix to the tube, but I doubt whether inflammation of the appendix would cause inflammation of the tube, as it would be a very difficult matter for any pus to find its way into the tube. For that reason I would doubt whether the pain spoken of in the first paper was caused by inflammation of the tubes. In all those cases we have the salpingitis first, inflammation of the tube and afterwards a resulting appendicitis and it then becomes a true dysmenorrhœa, because of the inflammation in the tube and ovary, not because of the inflammation in the appendix.

DR. LEE: *Mr.Chairman, Ladies and Gentlemen:* I think it is wise to do too little in a case like that presented by Dr. Cox rather than to do too much. This was the plan in vogue several years ago in the treament of pus in the pelvis from purulent salpingitis. At that time we all remember how we used to flush the abdomen with sterile water, pouring in a number of pailfuls if necessary, in order to cleanse the cavity. This spread the pus throughout the peritoneal cavity and gave rise to septic peritonitis frequently when it might have been prevented by limiting the septic matter. If it is necessary to break down adhesions, the surgeon would make a long incision and then, by suitable gauze pads, press back the intestines out of the field of operation and complete the work without seeing them. Then, by using the Trendelenberg position the work can be completed nicely, and the infected field cleansed with salt solution or peroxide of hydrogen. But I doubt the propriety of breaking up all adhesions and removing all of the adventitious tissue and trying to do an ideal operation.

DR. SYDNEY WILCOX: I would like to ask Dr. Lee one question. Suppose you have an abscess which occurs as the result of appendicitis and the abscess has been thoroughly walled off and you make an operation for the removal of the pus, do you attempt to remove the appendix at the same time? Do you hunt for it? Do you think it best to do that or leave it alone?

DR. LEE: In a case of that kind, if the appendix can be found readily and removed without breaking down the wall of adhesions which nature has erected, remove it. Otherwise, it is better to leave it alone, and, at a later date, remove the appendix.

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# LEUCORRHŒA.—ITS DIAGNOSTIC VALUE AND HOMŒOPATHIC TREATMENT.

H. D. COCHRANE, M. D.,
ALBANY.

Leucorrhœa results from one or both of two great causes, namely, a local pelvic congestion or a morbid constitutional condition such as is found in anæmia, Bright's, etc.

While it is true that all discharges from the genital track are composite in their nature, yet there is usually one element that predominates sufficiently to classify them under one of the following heads: mucous, purulent, watery, sanious, offensive and corrosive discharges.

It is also true that while a leucorrhœa is not the disease *per se*, yet its character often leads to a correct diagnosis of the underlying malady and furthermore, often serves as a guide pointing to the true remedy for the case.

Let us consider first the *mucous discharges*. When of an acid reaction, curdy looking and containing in suspension epithelial debris in quantity, the source is the vaginal mucous membrane, it signifies either an inflammation, simple or specific, or aphthous ulceration. When the discharge is soapy looking or is composed of vitreous lumps of coagulated mucus or of a tenacious albuminous character resembling the raw white of an egg, and of an alkaline reaction, we know the cervix is the seat of an endocervicitis or a cystic degeneration.

Again, if the mucus be of a creamy character and tolerably profuse and constant, the uterine cavity is the source of trouble, indicating an exaggerated normal secretion after menstruation or during pregnancy; the early stage of inflammation, simple or specific; or a constitutional disease, such as anæmia or Bright's.

*Purulent discharges* may be thick or thin, profuse or scanty, fetid

or odorless, and originate from any portion of the genital track, indicating a chronic inflammation, either simple or specific. If the latter the discharge is usually thick and yellow and contains gonococcii. When the quantity is considerable and non-continuous it is probably due to partial cervical obstruction. A sudden purulent discharge of a very large quantity from the uterus or vagina, followed by relief is strongly indicative of pelvic abscess.

*Watery discharges.*—When of a urinous odor point to vesico-vaginal or vesico-uterine fistula and are frequently involuntary when laughing or coughing. When odorless and of variable quantity, together with a history of pregnancy, it is suggestive of amnionic fluid.

If hydatiform bodies are contained in the fluid a diagnosis of hydatiform mole could safely be made. A rare condition is an ovarian cyst rupturing into a tube or into the uterus, in which case there would be a discharge of a dark brown fluid.

*Sanious discharges* are of a mucous or watery character with an admixture of blood elements. When from the cervix it relates to abrasions or ulcerations. When uterine it is associated with menorrhagia, polypi and fibroma, also fungoid and granular endometritis. When pelvic hematocele is the cause we have blood tinged pus in large quantity, a previous history of shock, collapse and inflammation.

*Offensive discharges* are of variable quantity and frequently sanious. Their source may be from any part of the genital track. Their significance, retained products of conception; sarcoma after necrosis of tissue occurs, the discharge resembling the washings of fresh meat; true carcinoma after necrosis of tissue commences; or retained menstrual blood due to a want of cleanliness.

*Corrosive discharges* are caused by a hyper-acidity of the vaginal secretions, carcinoma of the cervix or syphilitic conditions.

Regarding the treatment of leucorrhœa and the underlying disease of which it is a symptom, there are three methods open to the homœopathic physician that may be used either singly or combined, i. e., (1) local treatment, including douches, direct medication and mechanical appliances; (2) surgical treatment, including the use of curette and knife; and (3) the symptomatic treatment.

At the risk of wearying the members of this Society I wish to mention the indications for a few of our therapeutic gems, in the hope that some stray word may help a brother physician in a similar case.

Belladonna.—When congestion is great and catarrhal discharges are not profuse and of simple mucus.

Calo. Phos.—In leucorrhœa of little girls; profuse, milky and purulent.

Eucalyptus glob.—Profuse, catarrhal, yellow discharge from enlarged, swollen, cervical papillæ; it is corroding and irritating.

Hydrastis.—Very profuse, thick, yellow, tenacious leucorrhœa, of long standing.

Lilium tig.—Profuse, yellow or brownish, *acrid* discharge, associated with *flexions.*

Sepia.—Profuse leucorrhœa of a bland character, associated with *versions.*

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# SHOULD CATHARSIS PRECEDE LAPAROTOMY?

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In both theology and law we are accustomed to believe that dictum has a great power. It is commonly known that a statement which is presumably verified, finding a place in the literature of either of these professions, is likely to remain for decades, and even centuries, without being seriously called in question. Few, however, stop to think that the same may possibly be true in medicine. That this is a fact has often been verified, and I take the liberty of calling to the attention of the Homœopathic Medical Society of the State of New York, the possibility that one of the supposedly important preliminaries to abdominal operations, and I may say, to all major operations, and even to anæsthesia itself, is merely a dictum, without foundation in science, the value of which falls short of demonstration in practice, and which when followed as a routine, may prove deleterious and even fatal.

The dictum referred to is that, previous to laparotomy in particular, it is advisable that the patient should be given a cathartic. Some refer to this cathartic under the name "aperient," some "laxative," some "purge," some "saline;" but whatever drug, or combination of drugs the writers may have in mind, we are bound to assume that they intend to advise that the bowels be actively moved by a cathartic medicine of one sort or another. In fact, before administration of the dose, whatever it may be, it is frequently impossible to say whether it will act merely as a laxative, an aperient, or a purge, so that in general we are justified in assuming that catharsis is intended.

Time and energy have not permitted the writer to assume the herculean task of looking up *all* the authors upon this subject, but he begs to quote some short extracts from books immediately before him, and familiar to all, and to say that this practice is so universal that when the term "usual preparation" is used, hardly a physician present would fail to include in that "usual preparation" or laparotomy, the customary cathartic.

T. Pickering Pick, 1899, says: "The bowels should during this " time be acted upon by a mild aperient daily, and a warm bath given " every night."

A. Ernest Maylard, in Surgery of the Alimentary Canal, 1896, speaking of appendicectomy, says: "The bowels should be emptied "by aperient medicines, and by the use of copious fluid enemata on "the morning of the operation."

George Ernest Herman—Diseases of Women—1898, in speaking of ovariotomy, says: "The bowels should be cleared by an aperient "given the night before, aided by an enema on the morning of the "operation."

Charles McBurney, writing in the Warren-Gould Text Book of Surgery, 1900, under the title, "Technic of Aseptic Surgery," not confining his advice to any particular class of operations, under the caption, "Preparation of the Patient," writes: "Generally a suitable "laxative should be administered on the day before operation."

James C. Wood, Text Book of Gynæcology, 1894, writes: "In "abdominal cases the bowels should be emptied the day before oper-"ation with a cathartic, and the morning of operation with an "enema."

Alexander J. C. Skene, 1890, speaking of ovariotomy, writes: "On "the morning of the day before the operation, a medium dose of "castor oil should be given."

In the American Text Book of Surgery, page 1067, edition of 1892, the author says: "The night before the operation he should "have a mild laxative, and an enema the morning of operation."

Kelly, in his admirable work on Operative Gynæcology, writing in 1898, advises the administration of "Citrate of magnesia, castor oil, "epsom salts, licorice powder, or a pill of aloes, strychnia and bella-"donna to the point of free purgation."

W. E. Green, in the Homœopathic Text Book of Surgery, writing upon "Operations for Diseases and Injuries of the Intestines," says: "The day before the operation a brisk saline purge should be admin-"istered, one tablespoonful of rochelle salts given in a tumbler of "hot water, will answer well; however, if this does not act in from "four to six hours, one-half the quantity should be repeated."

Pozzi, in his work upon Gynæcology, writes: "The bowels have "been emptied by a purge the day before and by an enema in the "morning."

This very small list of authors comes from the book-shelves without selection, and it cannot be questioned that they represent not only the *common*, but the almost invariable practice of the times. The writer does not recall an author who omits the cathartic, or who calls in question the value of the practice.

For the ten years preceding October 1st, 1899, it has been the writer's custom to follow the above dicta on all occasions when it was possible to do so, but there have been times as in the history of all surgical work, particularly abdominal work, when the emergency would not permit what we ordinarily consider careful preparation of the patient, and the result of these emergency operations has been so encouraging that early last autumn it was decided to abandon catharsis preceding laparotomy, and substitute evacua-

tion of the rectum and large intestine by enemata merely as an experiment. This decision was not reached without considerable thought, and the main theoretical points determining the decision were these:

First: The effect of similar doses of cathartics upon different individuals has, in our experience, varied very widely, the dose which in one person would hardly give a satisfactory movement, producing in another active purgation.

Second: We hold to the belief that it is advisable that the patient's vessels should, at the time of operation, be filled to their utmost with fluid, and believe that catharsis tends to reduce the amount of this fluid.

Third: That aside from the lessening of the circulating fluids, catharsis exercises an extremely depressing effect upon many, if not all individuals, and that this condition is far from desirable at the time of operation.

Fourth: That it is the writer's experience that there is no exception to the rule of catharsis being followed by a reactionary constipation, which occurring as it usually does, during the first few days after operation, not only does damage by retarding the normal intestinal peristalsis, but also causes the surgeon untold anxiety, which is only dispelled when, after repeated efforts, he has brought about an action of the bowels.

Fifth: That the effort to secure the first movement after a grave operation, often requiring enormous doses of drugs, comes at a time when the patient is in no condition to tolerate such treatment, and it is not outside the range of probability that fatalities have resulted, when the factors working toward recovery and death have been evenly balanced.

Sixth: In cases where there is recent pus formation in the abdomen with recent adhesions, we feel sure that the violent peristalsis following the use of a cathartic, is liable to result not only in damage, but occasionally in death.

We must say that we have very little faith in the idea that drainage of the abdominal cavity can in any way be facilitated by way of the intestinal tract, but we do recognize that as a symptom of the well being of the patient, there is nothing which takes precedence over early passage of flatus and evacuation of the bowels after major abdominal procedure.

As a result of the general impression gained during the past four months, while substituting evacuation of the large intestine by means of enema, for the usual preparation by means of cathartic, we have been so thoroughly convinced of the possible superiority of this method, that, with the assistance of Dr. P. C. Thomas, Resident Surgeon of the Hahnemann Hospital, New York, we have collected, and beg herewith to present the immediate history of twenty-two consecutive cases, operated during this time.

Mrs. H. F. O, aged 22. Operation October 16, 1900. Hahnemann Hospital, No. 8363. Diagnosis, double pyosalpinx and pelvic abscess;

abdomen closed; abscess opened through vagina. Preparation included four drachms licorice powder, followed by four movements October 15th. Operation on October 16th, consisted of an exploratory laparotomy, followed by immediate closure of abdomen, and opening of an abscess by an anterior colpotomy. Patient suffered a great deal of abdominal pain from accumulation of gas, and on October 17th was given repeated small doses of merc. dulc., followed by an enema of one ounce sulph. magnesia and water, which resulted in passage of considerable gas. Bowels, however, did not move until three days later. Wound healed by first intention.

Mrs. F. D., aged 38. Hahnemann Hospital. No. 8352. Diagnosis, left pyosalpinx, right salpingitis. Preparation included two drachms licorice powder, October 11th, one drachm October 12th, followed by three soap-sud enemata. Operation October 13th, left salpingo-oophorectomy; duration, one hour and forty-five minutes; no gas passed. On October 15th was given calomel and soda, followed by magnesia sulph., which resulted in action of bowels October 17th. Wound healed by first intention.

Miss H. D., aged 41. Hahnemann Hospital, No. 8365. Diagnosis, retroflexion of uterus with adhesions. Preparation included no cathartic and only one enema. Operation October 17th, ventro-fixation, duration forty minutes; passed flatus in eighteen hours; bowels moved on fourth day, after administration of small doses of merc. dulc., followed by mag. sulph. one ounce and an enema. Wound healed by first intention.

Miss A. D., aged 29. Hahnemann Hospital, No. 8422. Diagnosis, appendicitis, with abscess and perforation of colon. Preparation consisted of three enemata. Operation, November 9th, appendectomy and suturing the perforation, duration two hours fifteen minutes. Convalescence uneventful, without discomfort, twenty-one days; healing by first intention, with granulation of drainage tracts; stool November 12th, following enema.

Miss M. A., aged 37. New York Medical College and Hospital for Women. Diagnosis, tubercular-peritonitis of appendical and pelvic regions. Preparation, November 12th, licorice powder two drachms, resulted in two fluid movements. Operation, November 13th, appendectomy. November 14th and 15th, intense headache, some abdominal distension; November 16th, decided best to move bowels, and for that purpose it required numerous small doses of merc. dulc., followed by mag. sulph. two drachms, an enema olive oil and glycerine, followed again by soap-suds enema; healing by first intention. Left hospital December 5th, improved.

Mrs. V. M., aged 45. English. Hahnemann Hospital, No. 8,460. Diagnosis, appendicitis with abscess. Preparation consisted of three enemata. Operation 9 a. m., November 28th, first opening abscess, second, appendectomy, third, posterior colpotomy with drainage; duration of operation, two hours; stool and flatus within twenty-four hours; wound left open for drainage. Healed by first intention after secondary suture.

Mrs. M. K., aged 27. German. Hahnemann Hospital, No. 8,470. Diagnosis, ruptured tubal pregnancy. (Reported before Academy of Pathological Science, New York.) Preparation of intestinal tract consisted of enemata only. Operation, November 30th, left salpingo-oophorectomy, 4:40 p. m.; duration, one hour forty-three minutes. Flatus 9:50 p. m. same day, November 30th. Stool 2:30 p. m., December 1st. Recovery uneventful except small hæmatoma in line of incision, cavity of which granulated; in hospital thirty days.

Miss L. B., aged 28. Hahnemann Hospital, No. 8,426. Diagnosis, left pyosalpinx, and right multiple ovarian cysts with acute pelvic peritonitis. Preparation, soap-suds enema; constipation a marked symptom. Operation December 1st, double salpingo-oophorectomy. Flatus December 4th; stool after enema, 1 a. m., December 7th. Wound healed by first intention. No tympanitis or unusual gas pain. Recovery uneventful, twenty-one days.

Mrs. W. B., Washington, N. J. Diagnosis, ovarian cyst, with twisted pedicle, undetermined pathological condition—pregnancy. Operation, December 2nd, in Washington. Removal of cyst; suffered very little from gas pains. Bowels moved after use of merc. dulcis$^{1x}$, followed by an enema. Miscarried on third day. Convalescence uneventful. Healing by first intention.

Mrs. M., aged 38. German. Hahnemann Hospital, No. 8,483. Diagnosis, lacerated cervix and perineum, rectocele, cystocele and procidentia-uteri. Preparation of intestinal tract consisted of the administration of enemata. Operation, December 5th, 2 p. m., duration, two hours, eight minutes: 1st, supra-vaginal amputation cervix; 2nd, anterior colporrhaphy; 3rd, perineorrhaphy; 4th, ventro-fixation. Stool December 8th, after soap-suds enema. Healing by first intention; convalescence uneventful, twenty-five days.

Mr. F. A. S., West 88th Street, New York City. Diagnosis, appendicitis with abscess, and intestinal obstruction from volvulus. Preparation by enemata. Operation, December 13th, appendectomy, liberation of adhesions with capillary drainage; passage of gas and fæces within few hours. (Record not complete.) Recovery complicated by hepatic colic on fourth day. (See later report.)

Mrs. H. F. O. Hahnemann Hospital, No. 8,363. Second operation. Diagnosis, double pyosalpinx. Preparation, two enemata. Operation, December 14th, duration, two hours, twenty-five minutes; salpingo-oophoro-hysterectomy; universal adhesions; stool in twenty-four hours; flatus in forty-eight hours. Healing first intention, except about one inch of superficial wound infection. Convalescence uneventful, twenty-three days.

Mrs. S. F., aged 27. Hahnemann Hospital, No. 8,522. Diagnosis, intra-ligamentous cyst—right side, cystic ovary—left side, sub-serous uterine fibroid. Preparation by enemata. Operation, December 19th, 2 p. m., 1st, left salpingo-oophorectomy; 2nd, enucleation of intra-ligamentous cyst; 3rd, resection right ovary; 4th, resection of outer half right tube; 5th, myomectomy; flatus passed within twenty-four hours; no tympanitis; gas pains and vomiting slight; stool in forty-

eight hours, following S. S. enema; convalescence uneventful, twenty-one days. Wound healed by first intention.

Mrs. E. E. K., aged 21. Hahnemann Hospital, No. 8,533. Diagnosis, double pyosalpinx and cystic ovaries (gonococcus). Preparation by three S. S. enemata. Operation, December 26th, 9 a. m., time, two hours ten minutes, salpingo-oophoro-hysterectomy, with universal adhesions. Flatus in forty-eight hours, stool seven hours later. Obstinate constipation had been a marked symptom. During operation the colon was found to be full of hard fæcal masses, therefore, forty-eight hours after operation, she was given merc. dulc. two and one-half grains in divided doses, which resulted in evacuation of the bowels. Convalescence uneventful and without discomfort, twenty days. Wound healed by first intention.

Miss M. E. B. Hahnemann Hospital, No. 8,550. Diagnosis, chronic appendicitis. Preparation, one enema. Operation, January 7th, 9 a. m., time, twenty-seven minutes, appendectomy. Flatus in twenty-four hours, stool in forty-eight hours, following enema. Healing first intention. Convalescence uneventful, sat up on 9th day, left hospital on 13th day.

Mr. F. A. S., aged 21. Hahnemann Hospital, No. 8,547. Diagnosis, obstruction of cystic duct and cholecystitis. Preparation, two enemata. Operation, January 7th, 2 p. m., time, one hour, thirty-seven minutes, cholecystostomy with drainage. Flatus in twenty-four hours; stool third day, following enema. Recovery uneventful and without discomfort.

Mrs. A. M. G., aged 32. Hahnemann Hospital, No. 8,538. Diagnosis, multiple cystic left ovary with adhesions. Preparation, two enemata. Operation, January 7th, left oophoro-salpingectomy, one hour, twenty-three minutes. Stool in twenty-four hours, flatus following. Healing first intention; convalescence complicated by pelvic exudation; up in twenty-five days.

Mrs. W., Binghamton, N. Y. Diagnosis, acute appendicitis. Preparation, cathartics had preceded my first visit. Operation, January 10th, appendectomy, with capillary drainage. Flatus passed and bowels moved within twenty-four hours, drainage removed at end of twenty-four hours, followed about twenty-four hours later by sudden rise of pulse, collapse, and in about twenty-four hours more by death. This fatality was not in any way attributable to treatment of intestines, nor to care which patient received during my absence, but was, in my opinion, due to my order to remove drainage at the end of twenty-four hours, which I consider a very dangerous procedure.

Miss E. K., aged 12. Hahnemann Hospital, No. 8,562. Diagnosis, left inguinal hernia. Preparation, enemata. Operation, January 12th, Bassini, fifty-eight minutes. Flatus unrecorded, stool in forty-eight hours, following enema. Healing first intention. Convalescence uneventful, twenty-one days.

Miss E. G., aged 10. Hahnemann Hospital, No. 8,567. Diagnosis, acute appendicitis, first attack. Preparation on table at midnight.

Operation, appendectomy, January 12th, fifty-five minutes. Stool third day following enema; flatus unrecorded. Healing first intention; convalescence uneventful, twenty-one days.

Miss E. F. New York Medical College and Hospital for Women. Diagnosis, right floating kidney and appendicitis, stenosis of cervix. Preparation, two enemata. Operation, February 1st, nephropexy, appendectomy, dilatation and curettage, one hour, thirty minutes. Flatus unrecorded; bowels moved on fifth day, following enema; no pain, no tympanitis; unusual nausea unaccounted for. Healing by first intention.

Master L. W., aged 4 years. Laura Franklin Free Hospital for Children. Diagnosis, left congenital inguinal hernia. Preparation, licorice powder one drachm, administered without orders. Operation, February 2nd, Bassini's operation for hernia. Flatus unrecorded. Bowels inactive, moved on 6th day, following enema. Urine very scanty, but no great discomfort. Recovery uneventful. Healed by first intention; still in hospital.

Our conclusions in this matter are that while the number of cases which we are able to report at present is too small to form a basis for positive judgment, yet, comparing their history with that of many patients operated upon under exactly similar circumstances (except that catharsis preceded the operation as a routine), we fail to see the advantage of the catharsis, and desire to express the opinion that patients, as a rule, behave better after operation, have less pain, less tympanites, and less general discomfort when the operation has been preceded by a thorough evacuation of the large intestine by means of repeated enemata, than where the cathartic has been used as a routine.

We can now recall numerous cases where it appears to us that the supposed post-operative intestinal obstruction, which has brought to us many a wakeful night, and, we are sorry to say, has, on one or two occasions, ended fatally, may have been due to intestinal paresis, which is the usual reaction following catharsis.

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## DISCUSSION.

DR. L. A. MARTIN: In justice to Dr. Roberts, whose technic is above reproach, I want to make a few remarks on this fatality of which he speaks. Not only is it necessary, coming from a man with such a series of cases, but I think it brings up a new point in surgery and one with which Dr. Roberts was unfamiliar at the time of his writing. This patient on whom he operated had diphtheria in the family for a space of ten days to two weeks previous to the operation and during that time she had received an immunizing dose (about 600 units) of antitoxin. And at the time of her death there was no sign of granulation or union of any sort. The wound was practically as free from union as after the operation. I think it was due either

to the poison of the antitoxin or diphtheria or both, and I would like to know whether that circumstance has arisen among the operators present.

DR. VALENTINE: What was the diet in these cases, milk or what?

DR. ROBERTS: Preceding laparotomy, animal diet, excluding milk; meat broth, very little bread, little potato, large quantities of water.

DR. VALENTINE: After the operation?

DR. ROBERTS: Previous to the operation. After the operation the first food is some form of strained broth and sometimes koumiss. Usually I start with solid food at the end of two or three days; but the point I wished to bring out is, if they are not given a cathartic beforehand they do not need as much afterwards.

DR. COLLINS: *Mr. President*—I have had just as good results from operations that have been done hastily, cases especially in acute appendicitis where there has not been time for free evacuation of the bowels with a cathartic, in fact, better results than where there had been a large cathartic previously, and I think it is unnecessary, unless we suspect there is an impaction in some part of the canal. I think the enemas are sufficient in most cases, but if a cathartic is given the bad effects of it can be overcome by giving them two quarts of water on the day previous to the operation, stopping the water six hours before the anæsthetic is given.

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# REPORT

OF THE

## BUREAU OF PUBLIC HEALTH.

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"State Protection from Animal Tuberculosis," - - F. PARK LEWIS.

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## STATE PROTECTION FROM ANIMAL TUBERCULOSIS.

F. PARK LEWIS, M. D.,
BUFFALO.

It is not my purpose to present a paper upon animal tuberculosis to this Society. This topic was ably considered at our annual meeting one year ago, by Dr. D. H. Arthur. The subject is, however, of such vital importance and the conclusions to which the facts

elicited give warrant have such a profound import to every citizen living in the State, that it is not enough for us to discuss the propositions involved, but we should follow up the discussion with effective action in support of the efforts already undertaken by the efficient health board through its "tuberculosis committee." Let me in brief cite the indisputable facts.

The modern plague, the white death, is strikingly uniform in the number of its victims. In 1898, at which time was published the latest volume of the reports of the State Board of Health, there were 12,979 deaths from consumption during the year. For the ten preceding years, the average mortality from this cause was 13,070 deaths. Tuberculosis is recognized as an infectious disease.

It is especially common in cattle and hogs. The flesh of these animals form the staple articles of our meat foods.

The one almost universal food of mankind is milk. The amount of milk consumed annually in the city of Buffalo alone, is nearly seven millions of gallons.

Now while it is known that tuberculous cattle are a direct source of danger to human life, through the flesh and milk, there is even yet no general universal health inspection of the cattle brought across our borders and of the herds within our State.

In the second annual report of the Commissioner of Agriculture, issued in 1895, occurs the following impressive statement:

"If the discoveries of scientific investigation are correct, and the disease known as tuberculosis can be transmitted through the milk of infected cows, *there is extreme danger to the people from such infection.*"

Five years' additional investigation have proved incontrovertibly how incalculably great is this menace to the health of the community. Dr. Arthur, in his valuable paper, reports a definite epidemic of tuberculosis which originated in the State Hospital at Middletown through infected cattle. While those first attacked all died, the recognition of the source of the disease, and the slaughtering of the infected cause, stopped its further progress, and tuberculosis was ended in that institution promptly and immediately. There lies before me at the present moment the twenty-ninth annual report of the Buffalo State Hospital. In it Dr. Hurd states that out of a herd of sixty-four, six cows were found tuberculous and slaughtered. In the Elmira Reformatory, according to the annual report for 1900, "it transpired that the herd of eighteen cows belonging to the institute had never been tested for tuberculosis. The State Veterinarian was called, made the usual tests, and condemned five whose milk was in daily use. These animals were slaughtered and the autopsy showed the disease in advanced stages." In the report of the tuberculosis committee instances like the above occur again and again.

"The abdominal and thoracic infection of the young cattle is shown in a striking manner." Tabes mesenterica, resulting in the starvation of the babies is probably invariably due to milk infection. "The probability of milk infection and the facts leading to the presump-

tion that dairy stock has been infected by such means," says the committee report, "has been too often passed by, and the danger made too little of by those who are steadily apologizing for tuberculous cattle."

On May 26th a single cow in the village of Waterloo was reported as diseased. The tuberculin test proved tuberculosis. The milk of this cow had previously been sold in the village. It was never determined how many human lives were lost by reason of this one infected source of supply. "Dr. Demne records the cases of four infants in the Child's Hospital at Berne, the issue of sound parents without any tuberculous ancestry, that died of intestinal and mesenteric tuberculosis as the result of feeding on the unsterilized milk of tuberculous cows." "Dr. E. O. Shakespeare attributes one-fifth of all deaths in infants and young children feeding on milk to tuberculosis, usually commencing in some part of the digestive organs."

These facts, then, may be considered as substantiated:

1st. That tuberculosis is an infectious disease.

2nd. That it is the cause of an immense mortality among our people.

3rd. That it is largely controllable by eliminating the chief source of infection: the diseased cow and her product—milk.

4th. That while we are undertaking and wisely, the State Hospital care of the tuberculous sick, we are making most inadequate provision for the suppression of the cause of the disease, and until this is done the cost of the State in valuable human lives, and a constantly increasing outlay for hospital care will be enormous without adequate compensatory returns.

The tuberculin test, which is the only trustworthy method of determining the existence of consumption in animals, is made by the representatives of the State Board of Health, when requested by the owners of cattle, and when the appropriation is sufficient to warrant the expense. There has been no appropriation for three years. In a bill now before the Legislature amending the agriculture law relative to domestic animals, an appropriation of ten thousand dollars is provided for compensating the owners of animals slaughtered for tuberculosis.

The same amount was provided by the laws of 1897 for making a tuberculin test on suspected animals. Concerning this, the tuberculosis committee of the State Board of Health reports that: "It is obviously impossible with the small amount of money at our disposal to keep at Buffalo or other places, inspectors to examine and tuberculin-test the cattle designed for dairy or breeding purposes. Under existing laws we believe it a matter of greater importance from a sanitary standpoint, as well as of value to the cattle industry, than the inspection of beef cattle now so carefully carried on by the Bureau of Animal Industry."

The method of protection will require careful study, but it is of interest to know that "the Syracuse Board of Health passed an ordinance requiring all peddlers or dealers of milk, furnishing milk within

the city limits, to file with the Board a clean bill of health of all cattle supplying their milk, the certificate of health to include the tuberculin test."

In consideration of the importance of such examinations in their bearing upon the public health, there should be no milk sold within the limits of the State until the dealers have supplied such certificates. When this shall have been done, the most important step will have been taken to stay the ravages of the most terrible disease with which we are afflicted.

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## DISCUSSION.

DR. R. A. ADAMS: I have not given particular attention to this subject. I am not prepared to discuss the paper, but I want to suggest that we have got to find other sources of preventive measures and other means for effective protection against tubercular disease in cattle than that of the tuberculin test. I believe it is unreliable and often misleading. I believe it is generally condemned by men most widely interested in a financial way in regard to the cattle involved, and I think nearly all of the large associations—cattle breeders' associations—are passing resolutions utterly condemning it, and they have investigated it to no small extent and are unanimously and firmly opposed to the test, though from both a business and humanitarian standpoint, all will eagerly welcome anything that will effectively prevent the spread of tubercular disease in man or beast.

DR. ASHLEY: I would like to ask whether the tuberculin test is condemned because it reveals or inoculates tuberculosis in the beast. I have had some experience with sixty-five head of cattle. In that herd forty head showed evidence of tuberculosis in response to the tuberculin test. I saw most of the cattle slaughtered and saw the tubercles which ranged in size from a walnut to that of a cocoanut. The finest appearing beast in the herd showed evidences of tuberculosis by the test and I have seen the tubercles after the animal was slaughtered.

DR. ADAMS: Did the tuberculin test give any indication for tuberculosis?

DR. ASHLEY: I have to add that in each case where it gave evidence of the test for tuberculosis, the animal, after being slaughtered, showed every evidence. Our herd was reduced forty.

DR. SPOOR: I saw a number of cattle slaughtered and I think there were three of them in which there was not a sign of tuberculosis in any part of the body. I examined the cases myself and so did the veterinary surgeon of the county and there was no evidence of tuberculosis.

DR. R. A. ADAMS: This will have to have deeper investigation. I want to quote from a recent article in the Leader's Gazette, a paper by the highest authority in that line, just one sentence in regard to

tuberculosis: "Its fallacy has been demonstrated; its effectiveness has been proved; its danger is undoubted." That is the conclusion of one who is best able to judge.

DR. TERRY: Can you give the process of this material used in the test? I remember reading—it is really a very important question—whether or not that which inoculates does any harm to those which are healthy. I would like to know the process.

DR. DEWITT G. WILCOX: I will endeavor to answer Dr. Terry's question. I think the question is particularly important at the present time, because of the certain suggestions of the Governor in his recent address. Up until the present time, including the present time, this matter has been in charge of the State Board of Health. They have a special committee appointed on tuberculosis, which is the only department of public health that receives any salary at all, and it is their business to investigate tuberculous cattle all over the State and they have the right by law to destroy cattle when discovered afflicted with this disease. It has brought about a quarrel between the cattle raisers and the State Board of Health, and because of that friction the Governor has been induced to suggest that the matter hereafter be taken from the Board of Health and be placed with the Committee on Agriculture. It is not supposed that this committee is in any wise capable of deciding the question of tuberculosis in cattle. It seems that nothing but experts can do it and it should come from the physicians. If these suggestions of the Governor prevail it will take from the State Board of Health this question of tuberculosis of cattle and place it with the Committee on Agriculture. So I think it is very well that this Society, as well as others, take some action regarding this matter.

DR. F. PARK LEWIS: I don't imagine that any of us can speak definitely as experts in regard to the value of the tuberculin test. The Board of Health presents an exceedingly exhaustive and immensely valuable report, cases reported in detail and a large number in which the findings are pictured and conditions of diseases of cattle shown most graphically. The value of the tuberculin test is not the question. That we cannot settle; it is a matter for the skilled veterinary surgeon. Though milk is the chiefest food supply of the human race, there is a very large number of infected cases, from tuberculously infected cattle. It has again and again been shown that infection is directly possible from milk of such cattle when given to the human kind. I think those are incontrovertible statements. The corollary would be that it is imperative as a matter of humanity and economics if we are to limit the amount of tuberculosis, that tuberculous cattle shall be excluded from use for meat and for milk. Those are the points I want particularly to bring before the Society, and when this bureau is closed I have a resolution relative to the Fancher bill, which I would like to introduce. (Resolution here read.) I have said nothing about the tuberculin test, but that the cattle supplying the milk food of the State shall be subjected to such inspection as will protect the people. I move this resolution, sir.

DR. L. A. MARTIN: I think Dr. Lewis's resolution is an admirable one.

DR. F. PARK LEWIS: It might be borne in mind that it is not necessary always to kill tuberculous cattle. After the seclusion of herds, in many instances, tuberculosis is a curable disease. Tuberculosis is a disease found where cattle are kept in confinement in cities. The question is one of such profound sanitary importance to every man, woman and child that I feel this Society can do no better professional work than to take up the matters contained in this resolution which I have had the honor to bring before you.

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# REPORT

OF THE

## BUREAU OF SURGERY.

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"Fecal or Intestinal Fistula: Some Personal Observations On," WILFRED G. FRALICK.
"The Importance of Early Diagnosis in Appendicitis," NEWTON M. COLLINS.

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## FECAL OR INTESTINAL FISTULA: SOME PERSONAL OBSERVATIONS ON.

WILFRED G. FRALICK, M. D.,
NEW YORK CITY.

When I was honored by an invitation to present a paper for your discussion to-day it occurred to me that the subject selected would interest you, and could profitably be discussed at this time. In choosing so broad a subject I have assumed to merely scan a topic, touching only the most salient features or those which have proved of greatest interest to me. While portions of my paper are apparently suggestive, the statements which I will make are in the main, the result of my personal observation, and I trust may prove sufficiently interesting to evoke your criticism, thus enabling me to share with you your experiences in conditions which entail so much suffering and which bring about such serious and distressing consequences.

During my fourteen years of professional work I have had under my care twenty-seven cases of fecal fistula. In this number I do not

include any cases of artificial anus. The distinction being that artificial anus is made intentionally by the surgeon in healthy tissue, while a fecal fistula is the result of a pathological process which has destroyed a portion of the gut at one or more points.

Fecal or intestinal fistula may communicate with another part of the intestinal tract, the bladder, vagina and uterus.

The causes which gave rise to the cases of fecal fistula or intestinal fistula from which my paper is formed are in their order of frequency:

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| 1st. | Appendicitis, - - - - | 11 cases. |
| | Pelvic and abdominal abscesses independent of appendicitis, - - - - | 9 cases. |
| 2nd. | Strangulated inguinal hernia, - - | 3 cases. |
| 3rd. | Strangulated femoral, - - - | 2 cases. |
| 4th. | Foreign body, - - - - | 1 case. |
| | Adherent Tumors, - - - - | 1 case. |

Other causes not within my experience, however, are cancerous deposits, gun shot and penetrating wounds, intestinal actinomycosis, sutures, foreign bodies in the intestinal canal, ulceration of the bowel, injury to the bowel during abdominal operations.

You will observe that appendicitis is the most frequent cause of fistula in the cases which came under my care. The fistulæ from this cause occur either by perforation or sloughing of the appendix, or the appendical abscess ruptures either into the cæcum or intestine. In either case there was an extensive local peritonitis with a limiting wall formed of inflammatory products which confined a sloughing or gangrenous appendix as well as the intestinal contents which had escaped.

I will cite one case which will serve to illustrate the pathological conditions present in the others which differed only in the degree of degenerative process in the bowel and extent of peritonitis.

On the morning of June 27th I was called in consultation by Dr. Raymond, of New Rochelle, to see a patient of his, a man about 48 years old. The patient gave a history of having had a trouble in the region of the appendix five years previous to the present attack. When I saw him he had been confined to his room ten days. His temperature was 102°, pulse 125, compressible and thready; the right thigh was flexed on the abdomen, the abdomen was tense, distended and tympanitic with an area of dullness above the crest of the ilium and well over toward the corresponding right side of the abdomen. Nothing had escaped from the rectum for thirty-six hours, nausea was present and the patient had vomited a brownish substance which I did not see but the attending physician thought he detected a fecal odor to it. I advised the patient's removal immediately to the hospital, and that enemata of oil and turpentine be given; also that the patent be prepared for an abdominal operation; which I did that afternoon. I made an incision about McBurney's point. When I had divided the skin, the tissues underneath were greatly infiltrated and gave to the sense of touch that peculiar crackling sensation met with in emphysematous conditions. The dissection through the remaining tissues except the fascia of the external oblique was made by dry dissection. When I had reached a point where I thought I

detected fluctuation, I carefully packed the surrounding parts with gauze and then opened into the fluctuating mass, from which escaped pus, fecal matter and intestinal slough, and with a slight effort I detached the distal end of the appendix. Careful as I had been not to disturb the infiltrated and friable tissues, a rent in the gut large enough to insert two fingers was brought into view. The parts were thoroughly cleansed with pure electrozone, the wound packed with electrozone gauze and with the usual outside dressings the operation was terminated. From the effects of this operation the patient reacted well and made an uneventful convalescence. During July and August I visited the patient frequently. By the middle of August the suppurative process as evinced by discharge of pus had entirely disappeared, intestinal contents alone escaping. On September 24th I visited the patient. The opening in the intestine admitted my two fingers. That with a knowledge that the slough had removed a large portion of the gut, I felt that spontaneous closure, if possible, would be too slow a process and even if successful, a stricture would surely ensue, I advised an operation for its closure, which on September 28th I performed. I made a resection of the bowel, joining the parts together by end to end anastomosis, using a Lambert suture of number 0 plain catgut for mucous membrane; for the muscular coat a continuous suture number 1 plain catgut; and for the serous coat a running suture of number 2 plain catgut. In the parietal peritoneum I used number 1 plain catgut; in the fascia, number 3 plain catgut; number 1 was again used for a cosmetic suture of the skin. I left an opening sufficient to admit of gauze packing, which was made to come in contact with the sutured gut. An electrozone compress was applied, over which was placed a pad of combined dressing and then a many-tailed bandage. The patient was returned to his room in good condition. The patient passed flatus the following day. A free evacuation of the bowels took place on the fourth day. All packing was removed on the seventh day, the wound being perfectly clean was allowed to granulate, which process was complete at the end of the third week. At the end of the fourth week the patient left the hospital cured.

I will briefly direct your attention to pus accumulations in the pelvic and abdominal cavities. Pelvic and abdominal abscesses caused but nine of the twenty-seven cases which I have to report. Statistics, however, gathered from many sources show this to be the greatest cause of these fistulæ. It is quite true that pus may remain encysted in the abdominal cavity for years without serious results to the patient. Many of us have removed pus tubes and encysted pus sacs or fistulous tracts from masses of agglutinated intestines where the history pointed to infection several years prior to the operation. Escape from danger may be explained in many cases where nature provides an exit for the pus through the intestines, rectum, uterus or bladder. These patients are, however, in a chronic state of invalidism, suffering from intra-pelvic pains and recurrent attacks of intra-pelvic inflammation. It is in these chronic cases that the ingenuity and skill of the surgeon are taxed to the utmost.

For the purpose of illustrating I will cite the following which presents characteristics common to many of the other cases.

The surgeon opens the abdomen, finds perhaps the peritoneum attached to the intestines, the intestine a mass apparently solid. He marvels that peristalsis is not arrested or that intestinal obstruction has not taken place. He looks for some landmark but sees none. The bladder, tubes and uterus are all interred; not dead, nor peacefully slumbering, but struggling to free themselves from the fibrous bands that hold them fast. His quick eye finds a vulnerable point, his deft fingers penetrate the ugly mass, his countenance brightens as he sees, perchance, a tube, which he follows a short distance; again his face assumes a serious expression—he is contemplative, for alas! the tube was but a fold of intestine, an appendix or a pus sac. He works on, ever ready to stop but no pretext presents itself. Finally the tube is reached hard fast to the colon. He separates them. Instinctively he sniffs, not twice or thrice but once and brushes away the granular mass, calls for an antiseptic and an intestinal needle and carefully closes the hole in the bowel, removes the appendix tube or old pus sac, packs the cavity and speedily terminates the operation. Not so with his anxiety—it has just begun; for several days must pass ere he knows not only whether his patient will survive the operation but whether a fecal fistula will result.

I have closed as many as five openings in the intestine in one patient during an operation such as I have just cited. I have removed a fistulous tract having four distinct arms, each opening into the bowel at a different point.

Strangulated hernia comes next in order of frequency, five resulting from this cause. The one which I shall mention is of such very rare occurrence that I am sure you will grant me the time I shall consume in discussing it.

On the morning of August 12th Dr. Connett, of Morristown, New Jersey, telephoned me and said that he had just seen what he took to be a strangulated femoral hernia and which he thought needed an immediate operation. I took an early train and operated that afternoon. I saw the patient at 2 p. m. Her general condition seemed very good. Her temperature was 99½°, pulse 100, vomiting quite often, color was brownish, odor of which was fecal. A large diffuse swelling, very tender, red, dull on percussion was seen in the right groin, in the region of Scarpa's space. My diagnosis agreeing with Dr. Connett's, the parts having been previously prepared, an operation was immediately performed.

An incision was made beginning about one and one-half inches below Poupart's ligament over the tumor and extending about two inches above it along the inguinal canal. At or near the lowest part of the incision a sac was reached and carefully opened. The contents consisted of a loop of small intestine, cæcum and vermiform appendix. The small intestine presented a greenish-grey, mottled appearance. The appendix and cæcum were black and gangrenous. The sac and contents were held fast by dense adhesions. I enlarged the openings, the saphenous and femoral, walled off the abdominal

cavity and after a tedious dissection returned the sac and contents to the abdominal cavity. I removed the appendix, stitched the diseased intestine to the abdominal wound, carefully packing, then completed my operation for the femoral hernia. The patient suffered very little shock. A few days later the bowels moved, mostly through the abdominal wound, forming a fecal fistula. Four weeks after the primary operation, I did a resection of the bowel, making an end to end anastomosis from which the patient recovered and is well.

I have consulted every available authority, foreign and domestic, and find no similar case.

I have had another case where the appendix alone was the sole contents of the femoral hernial sac.

Fecal fistula resulting from foreign bodies I have had but one case.

Three years ago a woman was referred to me for examination. She gave a history of having had a laparotomy performed for the removal of a tumor two months prior to her visit. She complained of severe pain on the left side in the region of the sigmoid flexure and left kidney. Her bowels acted with pain and great difficulty. Palpation revealed a large, hard mass in the above region. I advised an operation and two days later I performed it.

The intestines in the region of the tumor were drawn up into coils and matted together. After a dissection lasting three-fourths of an hour I reached the cause and removed it. A large gauze sponge which had been left in the abdomen after her first operation had imbedded itself into the small intestine and colon. The patient survived this operation for six weeks, during which time fecal matter poured from the abdominal wound. Death probably resulted from extensive destructive process in small intestine.

Fecal fistula of the intestino-vesical variety is also of quite rare occurrence. I saw one case of this kind in consultation with Dr. Trotter, of Yonkers. The fistula was very small and gave very little trouble; as the patient was 67 years of age I advised against an operation.

Adherent tumors gave rise to one case of fecal fistula. They were of the fibroid variety and had undergone calcareous degeneration. Adhesions and pressure caused a degeneration of the gut. After the tumors were removed a fecal fistula ensued. Seven of these fistulæ closed spontaneously, one remains open. One, the patient died six weeks after the primary operation; eighteen I closed by secondary operation.

I am aware that I have omitted to discuss many interesting and important features associated with fecal fistulæ, but the time allowed would not permit me to go more fully into the subject.

In closing, let me say that I believe, as a rule, those men will do the best work—will serve their patients best—who will adapt their methods and technique to the individual cases as they arise; who operate to relieve and cure their patients—not to demonstrate that this or that method is better than some other.

# THE IMPORTANCE OF EARLY DIAGNOSIS IN APPENDICITIS.

NEWTON M. COLLINS, M. D.,
ROCHESTER.

It is doubtful if any one appreciates the importance of early diagnosis in this dread disease more than the surgeon who sees these cases during operation just as they are! Some of our general practitioners are too prone to diagnose appendicitis as inflammation of the colon, or any disease other than appendicitis, and expect internal remedies to cure a condition which is purely surgical.

Is it strange that this blind pouch with its poor blood supply is so liable to become diseased, lying as it does at the junction of the large and small intestines, and opening only into the lower part of the ascending colon where impaction is most liable to occur, and where the colon bacillus is always found and is ready to attack this organ upon the slightest provocation? The appendix itself, as we know, is made up of tissue similar to the large intestine with a sub-mucosa especially rich in lymphoid glands; in other words, it has the peritoneal or serous coat on the outside, beneath which lie the muscular coats consisting of longitudinal and circular fibres. A mucous and a sub-mucous coat form its lining. This mucous lining, while healthy and intact, is not susceptible to disease from the germs that are constantly found in the intestines; but, as the appendix is only open at one end, the contents of the bowels are apt to enter into the open end and become lodged; the longitudinal and circular muscular fibres begin to contract to expel this foreign substance, and in doing so injure the mucous lining. Then the germs attack the lymphoid tissue underlying it and the trouble is begun.

This canal soon becomes strictured and the germs, which are back of the stricture, produce the pus which cannot pass out through the strictured opening but must have some vent; hence the perforation which so often follows.

Were the appendix open at both ends and larger in calibre it would be no more liable to disease than any other part of the intestinal tract.

This organ being very poorly supplied with blood is apt to become gangrenous and the strictured condition not only retards the venous circulation but causes such pressure on the nerve filaments that the pain is often lessened; so that we have no real indication of the amount of destruction that is going on, until rupture has occurred and the life of the patient is placed in jeopardy. At this juncture we pass from a surgical mortality of less than one per cent. to that of from twenty-five to fifty per cent. and even higher, unless the patient is in a position to be operated upon very quickly, or nature has walled off the appendix from the general peritoneal cavity; after

rupture has taken place, if the appendix is not walled off, medical treatment is of no avail. If it is walled off, which is quite uncommon, an operation is still necessary to drain off the pus and to remove the appendix, if it has not slougned off.

With these facts before us, which no one can gainsay, we should readily see that it is beyond the latest diagnostic power to judge as to the exact condition of the appendix, or to what extent the inflammation has gone; and if we would serve the highest interests of humanity, we should make our diagnosis early and give the patient the benefit of a one per cent. mortality, rather than subject him to the grave dangers following perforation.

We often hear people say that they would, or they would not, have an operation if taken with appendicitis. We little know how many have arrived at a decision in their own minds on this question, and the foregoing facts may aid us in proving the dangers of delay and non-interference.

The length of time before operation, after rupture, is all-important, as often one hour will change the chances from recovery to certain death. If much time is spent in getting consent to operate, after diagnosis is made, it may change the result.

Nearly all know how fatal a rupture of the intestines is during typhoid fever and if the conditions are shown to be similar, viz., the escape of the colon bacillus from the intestinal tract, where it is harmless, into the peritoneal cavity where it immediately produces peritonitis, at first localized and then general, they cannot but appreciate how necessary is the removal of the appendix before its rupture, and how every moment increases the danger of general peritonitis after rupture; I recently had a case that impressed this upon me very forcibly, which I will give in brief: September 29, 1900, I was called in consultation with Dr. Llewylln Sanders to see Master D., age sixteen years, who gave the following history. Two mornings before, September 27th, he called at the doctor's office for medicine for diarrhœa, with considerable pain, which was general; no localized tenderness, however, being found. He was sent home and ordered to bed. That night his people reported him as much better; the following morning the doctor found him with normal pulse and temperature, the diarrhœa and pain having ceased; that night the pain returned and became very severe, until at 5 a. m. he had one excruciating pain in the right iliac fossa. After this pain disappeared he seemed weaker than the morning previous, and the doctor was again sent for, and on calling at 10 a. m. he found the abdomen distended, the pulse 120, and temperature 102°. He at once diagnosed the trouble as appendicitis, and asked for consultation. At 12 o'clock the same day, we saw the boy, and examination revealed much distention, tenderness without pain over the entire abdomen, pulse 130, temperature 104°. The doctor's diagnosis was confirmed and an immediate operation advised, as he had every symptom of rupture having taken place. The operation was at first refused, as some of the relations asked for consultation with a phy-

sician who claimed to cure appendicitis without operation. We both declined to take any further responsibility in the case unless allowed to operate at once. This was finally consented to, just two hours after having first seen the patient. In the meantime preparation was made at the hospital for an immediate operation in case consent was obtained, so no time was lost, as he lived but a short distance away. (Here it might be well to add that to move a patient very far after suspected rupture is dangerous, and has undoubtedly caused many deaths, due to the necessary handling of the patient and jolting of ambulance or carriage. If advisable to move at all, he should be kept on the right side to prevent general infection of the peritoneal cavity. To my mind too much stress cannot be laid upon this precautionary measure.) Exploratory incision at 2 p. m. revealed a rupture of a gangrenous appendix with free pus in the abdominal cavity and beginning peritonitis. The appendix was at once ligated and removed, and with thorough drainage, we succeeded in saving the boy's life. Had we waited for further counsel, or delayed any longer, there is no doubt as to what the result would have been, as the appendix was not walled off from the general peritoneal cavity. His respirations the first night were 50, pulse 110, temperature 100°. On the following morning his condition was much improved and he made an uninterrupted recovery.

It is not strange that the diagnosis of appendicitis is difficult and even impossible to make in some cases, as it has been confounded with so many diseases; but if physicians, especially those living near hospitals, would take the time to watch a few of these cases operated upon, they would certainly appreciate the necessity of an early diagnosis.

The typical cases of appendicitis are usually easily diagnosed unless they are masked by opiates given in the endeavor to relieve pain. We cannot lay too much stress upon the importance of diagnosing all abdominal diseases before any opiates are given.

The early symptoms of appendicitis are well known to be pain and tenderness in the right iliac fossa, with rigidity of the right abdominal muscles; the pain often begins at the umbilicus and is accompanied by nausea and vomiting. This condition frequently follows indiscretions in diet, exposure, constipation, sudden strain or prolonged severe exercise, etc., etc.

The most common diseases that have symptoms similar to those of appendicitis are, acute indigestion, biliousness, obstruction of the bowels, typhoid fever, salpingitis, extra-uterine pregnancy, hepatic and renal colic, hernia, hysteria, and other less important troubles.

Acute indigestion has many symptoms similar to the beginning of an attack of appendicitis, viz., nausea, vomiting and pain with some fever; but if appendicitis is the cause of this disturbance, we will find rigidity of the right abdominal wall, and probably tenderness in the right iliac fossa at the end of twenty-four hours. A thorough movement of the bowels will relieve acute indigestion, while appendicitis—unless it be a very mild attack—will not be relieved by an evacuation.

Bilious attacks are differentiated in about the same way, and have many of the former symptoms, and may have some jaundice, but pain in the right iliac fossa and rigidity of the right side are wanting.

Intestinal obstruction is more sudden in its onset, with inability to pass any flatus. The pain is less apt to be localized, but when so, is usually found at the umbilicus, and at the seat of obstruction. Then, too, in the beginning of obstruction there is neither increase in temperature nor pulse. Fecal vomiting is a much earlier symptom in obstruction than in appendicitis, where it never occurs excepting late in the course of the disease. Shock and collapse are much more prominent symptoms of intestinal obstruction than of appendicitis, unless rupture has taken place.

Typhoid fever has usually a history of indisposition preceding the acute symptoms, general malaise, gradual onset, etc. It has no rigidity of right abdominal wall—a more general tenderness of the abdomen; roseola and enlarged spleen at the end of the first week and the Weidal test of the urine usually decide the case. Perforation of the bowels during typhoid fever has many symptoms in common with perforation of the appendix; but this comes later in the disease, after the diagnosis has been well established. This complication is more often mistaken for appendicitis in walking typhoids.

It is more difficult to diagnose appendicitis in women than men on account of the close proximity of the right tube and ovary to the appendix. Indeed, it has been proven many times, and was well illustrated by Prof. Wood's paper, read at the American Institute of Homœopathy last summer, that when one is diseased the other is very apt to be.

When the ovary and tube alone are affected, pain is usually lower down, and extends down the right leg; digital examination will reveal the unusual sensitiveness of these parts, and the movement of the uterus sideways will cause pain in the ovary and tube of right side.

Pain is worse preceding and during the menstrual period, and is not often accompanied by nausea and vomiting. Pain of appendicitis is near McBurney's point, and is not influenced by the menstrual period, and nausea and vomiting are apt to be present.

When extra-uterine pregnancy occurs in the right tube the symptoms may resemble appendicitis; but history of sterility, the enlarged uterus, the irregular bloody vaginal discharge, cessation of the normal menstrual flow, the location of the tumor lower down in the pelvic cavity, or the sudden collapse and symptoms of hæmorrhage following its appearance will usually decide in favor of tubal pregnancy.

In gall stone colic the pain is usually more severe and its location is higher up, viz., at the border of the ribs on the right side. But when the gall bladder is badly distended the pain may be found as low as the McBurney point. Dullness on percussion will then extend up to the border of the ribs. If gall stones are in the hepatic or common duct, jaundice is a distinguishing feature. In gall stone colic rigidity of the right abdominal muscles is lacking.

In renal colic, the urinary analysis, revealing an excess of uric acid, phosphatus of lime, blood, etc., is of assistance in diagnosis; as is also the relief of pain after micturition, and the location of the pain in the back and loin which is relieved by pressure.

The beginning of hernia has symptoms similar to those of appendicitis. If this is suspected from the history, the patient should be examined standing as well as lying down, when the beginning of the separation of the muscular fibres can be felt, and the cough impulse be more readily noted.

Hysterical and neurasthenic patients will give symptoms of any or all diseases imaginable, so the symptoms of pain and tenderness should be received with reluctance as diagnostic.

However, they cannot produce the right abdominal rigidity so characteristic of acute appendicitis. In chronic appendicitis even this rigidity is wanting, but the history of previous attacks will aid in diagnosis.

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## DISCUSSION.

DR. ROBERTS: I just want to say a word relative to the paper, as I consider it a very fine paper and appreciate it very highly and wish we had time to go into a larger discussion of the subject. There are two points—one in relation to differential diagnosis, between appendicitis and the passage of renal calculus—sometimes a very difficult matter to differentiate. It is all right if the patient has been passing stones or if there is some urine coming around the stone, so we can get an examination of the urine; but in case the stone is thoroughly impacted so that no urine passes, diagnosis is much more difficult. I have seen two cases of right renal calculus with symptoms which I have never seen recorded; that is, whereas in appendicitis we have marked tension of the right rectus, in the passage of calculus I found marked tension of the right external oblique. I thoroughly agree with the doctor on the importance of early diagnosis and the importance of early action, not because many of these cases will not get well themselves, not because the very large majority will not get well, but because we can never tell which case is going to have a history like that of the first one he reported. The vast majority where the rupture of the appendix takes place, and without the formation of adhesions, die whether operation is performed or not.

DR. GARRISON: From a standpoint of the general practitioner, I want to add my vote as to the early recognition of the disease. I remember having seen two cases in my own practice which seemed positively proper to be classed among those which were tending to get well; but in old cases operations were made and we found that the organ was in the process of becoming gangrenous and in both of those cases came very nearly too late to operate. In fact, in one case we were not able to save life.

DR. SCHALL: As regards pain, I have had an opportunity of hold-

ing autopsies in cases of appendicitis in those persons giving history of extreme pain in the lower abdomen. Two years ago there was a patient who was brought in who gave a history of extreme pain in the lower abdomen, left side. On account of the region of the pain, appendicitis was overlooked. This condition went on from bad to worse, and the patient finally died. I had the pleasure of holding the autopsy, and the last thing I thought of to look for was the appendix. I finally made my dissections down to a mass of adhesion, and came in contact with the appendix, which had ruptured and the whole right side, for about an area of four inches, was filled with pus, and the sinus, which was running down toward the bladder, and about ready to evacuate into the bladder, was present. Another case in which a woman complained of a very great deal of abdominal pain, but was never localized, except in the region of the umbilicus, and more toward the left side. She had suffered three days and it had been diagnosed indigestion. An old school doctor was called in and injected morphine. The symptoms were masked, and the patient died on the fourth day. The patient within ten minutes went into convulsions and died. The autopsy was made by myself, in which I found the appendix was ruptured and the right iliac fossa was filled with pus.

DR. DEWITT G. WILCOX: One point I want to make and that is the indications for suppuration. A great many practitioners think that their cases of appendicitis are getting along all right, unless suppuration takes place, but as those indications are so unreliable they cannot be depended upon. A great many general practitioners think that as long as they do not get chill, the case will not be a suppurative one. That is not true. In the majority of cases suppuration occurs without chill. I do find this to be a fact where there is a great disparity of pulse and temperature; we there get an indication of suppuration. If the temperature comes down (where both pulse and temperature have been correspondingly high), but the pulse remains rapid, we are sure to get suppuration; or, sometimes the reverse. But the disparity of pulse and temperature is a sign of suppuration.

DR. ROBERTS: I do not want to allow the impression to go out that it is the opinion of this Society that the reason that woman has appendicitis less frequently than man is on account of her having a poorer blood supply. The blood supply in woman is much better than in man, for the reason that the appendical artery has in many cases a direct anastomosis with the right ovarian artery and the reason that that protects them from sudden gangrene of the appendix is that the circulation being cut off on one side, is kept up on the other. The poor blood supply contributes to appendicitis in man, and good supply contributes to immunity from appendicitis in women.

DR. MOFFAT: I would like to ask whether the leucocytosis is a more prompt indication of the probability of suppuration having taken place than peptonuria would be, in helping to make up our minds as to whether there was pus there.

DR. SCHALL: In regard to the blood supply of the appendix, I am not quoting myself as being an authority, but quoting John B. Deaver, one of the recognized men of this country on that specialty. The blood supply is less in the appendix of women than of men.

DR. WILCOX: Is the colon bacillus present in pus where there is no perforation of the intestine?

DR. SCHALL: Yes, sir; it migrates very rapidly.

DR. ROBERTS: The statement has been made that where there is abscess, in which the colon bacillus was present, the patient universally died. Do I quote you correctly?

DR. SCHALL: As a rule.

DR. ROBERTS: That is very much against my experience and I think it is against the general experience of the surgeons. One of the most common things in opening an appendical abscess is to find colon bacillus pus and get the odor of fæces. That does not mean that there are fæces present, but it does mean that that pus is formed from the colon bacillus. Now, so far as the few cases I have seen, those cases recovered, provided they were treated on good surgical principles. I do not consider that the colon bacillus is a particularly violent infection. I want to suggest that as a matter of experience.

DR. SCHALL: I am referring to general peritonitis, in which the colon bacillus is present. This is the statement of Dr. William T. Bull. I wanted to give you the benefit of that. In general peritonitis, not in a localized abscess.

DR. GORHAM: I think too much cannot be said of the importance of early diagnosis in appendicitis. I had a case of a young man who, at three o'clock in the morning, awakened with pain in the abdomen on the *left* side. I saw him at ten. He had every indication of a severe attack of colic; no temperature, pulse 85. Pain continued through the day, somewhat abated by the treatment I gave him, and at 11 o'clock at night he sent for me; he was suffering. I gave him morphine. At seven o'clock in the morning they telephoned that the man had a chill. I ordered the ambulance to be at his home at 9:30. When I arrived I met the sister and mother and wife in an attitude of fight, but the boy went to the hospital. Three surgeons looked him over carefully and were in doubt as to whether this man had appendicitis. When he arrived at the hospital his pulse was 90, temperature 99; no soreness in the abdomen; pain all in the left side. He was sent to the ward. A blood count was made and we found he had a leucocytosis of 25,000. He was operated on at 4 o'clock and the appendix was found distended so full it was standing upright (indicating), liable to rupture at any moment, filled with very dark pus. It was taken out and the boy made a rapid recovery. Here was a case without temperature, or rise of pulse, without soreness and without tumor, and with pain on the *left* side. My diagnosis was confirmed by the surgeons after the blood count was made. This young man, in less than two years, had had two attacks of appendicitis.

DR. SCHALL: Dr. Van Lennep, of Philadelphia, had three such cases during my service there to which the doctor referred. It was

not decided for three days as to whether the operation would be made on the man, as the pain was on the left side. It was decided, however, to operate and pus was found in the appendix.

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# EFFORTS TO PERPETUATE ILLITERACY IN THE MEDICAL PROFESSION SHOULD BE EMPHATICALLY REBUKED.

HORACE M. PAINE, M. D.,
ATLANTA, GA.

The *Medical Century* for February, 1901, contains extracts from an article by Dr. A. C. Cowperthwait, of Chicago, in which he strongly urges the members of the homœopathic medical profession to unite in bringing about a repeal of the medical laws, enacted during the past few years, for the establishment of State control of medical licensure.

The establishment of State control, by elevating the standards of medical learning, as was purposely intended, has prevented large numbers of illiterate medical students from entering on the study of medicine.

The fact is to be recognized, that only the illiterate are excluded, the minimum limit of necessary educational qualifications being fixed, under these reformatory laws, by the legally organized representatives of the medical profession, instead of members of medical college faculties (commercial and irresponsible corporations).

Dr. Cowperthwait evidently regards this fact in the light of a calamity; an evil to be removed as quickly as possible; and he earnestly implores his homœopathic colleagues in this country to unite with him in efforts for bringing about a repeal of, what he considers, obnoxious medical laws recently enacted; these laws being found to materially interfere with the furtherance of his selfish purposes.

In common with his colleague, he feels that unless larger numbers of students can be obtained, the prosperity of the medical college with which he is connected, in fact, its very existence may be seriously threatened; and not only is his college endangered, but those also of numbers of other unsavory medical colleges, that are and have been for years foisting upon a generous and confiding profession, numbers of physicians who ought never to have been allowed to enter on the study of medicine.

Being confronted with the loss of patronage, he chafes under the reasonably restrictive provisions of examining board laws.

Under the guise of wider liberty, he proposes to turn liberty into license for the furtherance of the sinister purposes of self-constituted, irresponsible diploma mills.

He claims that laws establishing State control are unjust and tyrannical; yet everyone else, except himself and his illiterate or selfish associates, can see that the exclusion of ignorant students from participation in medical honors, cannot be reasonably considered an act of injustice, or, in any correct sense, an element of tyranny.

In urging homœopathic physicians to come to his aid he has stated reasons that are plainly widely at variance with truth; recommends action that is surely subversive of good order; and makes appeals which, if adopted, will brand his followers with dishonor and make them abettors of illiteracy.

The benefits derivable from State control of medical licensure are directly conducive to the promotion of public welfare, and indirectly to the more honorable standing of the medical profession; therefore, the lugubrious wailings of those who would perpetuate the evils of illiteracy, instead of being heeded and followed, are to be disregarded, and are to be considered as sure indications of the real value of State control, and as very gratifying evidences of its successful administration.

It is not necessary, in this connection, to enter on an elaborate argument in defense of State control. Its elevating, salutary and conservative forces are witnessed on every hand.

The fact, that for ten or more years, the tests of medical scholarship have been faithfully applied by examiners who are responsible to the recognized medical societies, has contributed largely to a most decided and prevalent feeling of confidence in the system, and of security from fraud in its administration.

In order to show how urgent is the necessity for actively supporting the present system of State medical licensure with all the force that we are capable of exerting, let me quote a few extracts from the report of the address of President Horndoerfer, presented at the last meeting of the National Association of Homœopathic Members of Examining and Licensing Boards.

"Dr. Horndoerfer held that the system of checks and safeguards, established by the various State examining boards, interposed the only reliable means for the permanent elevation of the standards of medical learning, and presented the only effective force that stands between the public and dense ignorance.

"Illiteracy prevails at the present time because of the notorious fact, that medical colleges in many States are not restrained by law from admitting students whose preparatory training is wholly insufficient to enable them to receive and retain the knowledge imparted.

"Numbers of students are constantly being admitted to medical lectures who have never been taught to think intelligently; to reason correctly; or to arrive at accurate conclusions from given premises.

"The hard earnings of these illiterates go to swell the college revenue, and in return an equivalent in the form of practical knowledge is presented; the student, however, being unable to make such knowledge personal, is defrauded.

"This questionable process is going right on, and, without doubt,

will continue until present lax methods are put under proper restraint by appropriate legislation.

"The special work of this association lies, therefore, in the direction of assisting to secure, State by State, such legislation as shall prevent attendance on medical lectures until the student shall have complied with certain preparatory requirements, such requirements to be determined and administered by an authority other than that of a medical college faculty.

"The examination and rating of the preliminary requirements of medical students should always be conducted under the auspices of the State educational department of each State, and never by the faculty of a medical college.

"The examination and rating of medical students as to their preparatory studies, as now conducted by many medical colleges, is a farce.

"An instance recently came to my knowledge in which the examination of a medical student, as to his preparatory studies, embraced simply a brief history of his own life written by himself. In another instance, the student, in his Latin examination, was given only two questions.

"Not five per cent. of medical students have received a Bachelor's degree, hence the rule requiring a completed high school education, as a preliminary requirement to an entrance on the study of medicine, is not by any means too high a standard.

"The degree of proficiency in medical studies has little bearing on the location selected for entering on practice. Educated and well-qualified physicians are equally needed, both in city and in country practice.

"Under the present system of flooding the country with illiterate physicians, it not infrequently happens, that the country farmer is better educated than the country doctor."

Inasmuch as there are evidences of organized antagonism to the principles of State control, I sincerely hope the influence of this Society may be exerted in favor of such principles, by the adoption of the following resolutions:

WHEREAS, Systematic and organized effort is being made to induce homœopathic physicians to oppose State control of medical licensure; therefore,

*Resolved*, That we hereby express approval of the principle of applying tests of scholarship by representatives of the profession, such representatives to be in no way connected with a teaching faculty.

*Resolved*, That we earnestly recommend the establishment of State examining and licensing boards, the plan of organization being such that the representatives of each of the recognized schools of medicine shall have coördinate powers of executive control.

# PROCEEDINGS

OF THE

## Thirty-Fifth Semi-Annual Meeting of the Homœopathic Medical Society of the State of New York, held in Buffalo, Sept. 24th to 26th, 1901.

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The double attraction of the semi-annual meeting and the Pan-American brought out a splendid attendance at the thirty-fifth semi-annual session of the New York State Homœopathic Medical Society. The Society convened in the parlors of Statler's Hotel, which was the headquarters. One hundred and twenty-seven physicians registered in attendance, which, with their visitors and friends, made up a delegation of over two hundred people. As evidence that the counter attraction of the Exposition did not deplete the attendance at the various sessions, it was noted that the hall was well filled, there being from sixty to eighty in attendance at each day's meeting. Statler's Hotel offered ample accommodation and there was plenty of room to spare. Had the attendance been five hundred, every one could have been provided with a room in this great caravansary of two thousand rooms. The arrangement of holding only forenoon sessions for three days, and allowing the afternoons and evenings free for the Exposition, proved a great success, there being ample time to complete a well-prepared program. It was significant that out of thirty-five papers, which were announced on the program, twenty-six of them were read. If the life of a meeting lies in the discussions, this meeting was very much alive, as scarcely a paper passed without free discussion; many of them were discussed by ten or a dozen members.

The meeting was called to order at 10:30 a. m., Tuesday, September 24th, by Dr. J. T. Greenleaf, President.

DeWitt G. Wilcox, Secretary.

Prayer was offered by Rev. O. P. Gifford, Buffalo.

*Committee on Attendance.*—George R. Critchlow, Buffalo; George H. Jenkins, Binghamton; Charles A. Gwynn, Auburn.

*Committee on Auditing.*—H. M. Dearborn, New York City; W. B. Winchell, Brooklyn; F. B. Seitz, Buffalo.

PRESIDENT GREENLEAF made the following remarks:

The Committee on President's Address will not be appointed at this session, because there will be no president's address. I might possibly take this time without trespassing to say that there are two matters, which may possibly not have occurred to the minds of the ladies and gentlemen present, that ought to be considered. We have a resolution which was offered at the February meeting tending toward a change in our method of election of officers. The resolution provides for the adoption of the Australian ballot. I think this is a matter which should not be adopted with a rush or without thought, nor should it be rejected without being considered in all its bearings. It is a matter that is most vital to this, as to any other society. I speak of it so that you may be thinking it over between this and the February meeting. We do not take it into cognizance to-day in any official way.

There is another matter which should be considered, as to whether this Society, fifty years old, is still young enough and virile enough to adjust itself to its environment; whether some little change ought not to be made to fit the changed circumstances. When the Society was organized it was practically the only thing of any size in this State under homœopathic auspices. Now we have a very large society here in the West. There is a strong Society at Syracuse and there is another strong one down in the Southern tier and there are two very strong county societies in New York, one in the Borough of Manhattan and the other in the Borough of Brooklyn. There is a question—I do not know that it will come up in an official way, even in February, but it should be considered—whether two meetings a year is a good thing to continue; whether it is not better to have one strong meeting and have it at a time when everybody can get out. February is a very hard time for physicians in the State to get out, though not necessarily so for those in the cities. Our hands are all full, and for that reason the meetings are a little small in February; and if there is a change made to one meeting, whether that should be held at the same time in the year or not. All these things, I say, should be considered, that is all. I do not offer them as a partisan in any way, and I do not offer them otherwise than just to attract attention thereto.

DEWITT G. WILCOX, Secretary, read the minutes of the last meeting, which were approved as read.

W. S. GARNSEY, Necrologist, reported the death of R. K. Valentine, Brooklyn; Jessie Shepard, Buffalo; J. D. Heinemann, Buffalo, and Oren G. Hunt, New York City. (See Appendix.)

## TREASURER'S REPORT.

WILLIS B. GIFFORD, M. D., in account with the Homœopathic Medical Society of the State of New York:

| | | |
|---|---|---|
| Dr. | | |
| Received from Dr. Deady | $ 666.29 | |
| Amount received from dues; February to date | 759.00 | |
| Interest on deposits | 7.24 | |
| Total received, - - | | $1,432.53 |
| Disbursements. | | |
| Bills paid by order of Secretary | $ 129.61 | |
| Bills paid by order of Treasurer, printing and stamps | 30.06 | |
| Bills paid by E. H. Porter, Chairman | 93.80 | |
| Bills paid by J. L. Moffat | 12.00 | |
| To Rochester Printing Co., Transactions | 628.15 | |
| To Francis E. Wessels, Stenographer | 30.00 | |
| To exchange on checks | 1.50 | |
| To cash on hand | 507.41 | |
| | | $1,432.53 |

The report was received and the Treasurer instructed to notify members, residing at a distance, to include in their remittances, exchange on checks.

## REPORT OF THE COMMITTEE ON INCREASING THE INTEREST IN MATERIA MEDICA.

In response to a circular mailed in the middle of August to each member of this Society, Drs. W. Ide Pierce, J. W. Dowling, F. B. Seitz, E. R. Bedford and H. D. Cochrane have reported the following verifications. It is hoped that a more general co-operation will enable us to make next February a more valuable report.

The circular requested:

(1.) Please copy from any Materia Medica (Allen or Cowperthwait) and send to the undersigned all such symptoms of these remedies as you are satisfied that you have verified in your own experience:—Agar., alum., amm. carb., arg. nitr., bism., carb. an., carbo veg., caul.

(2.) Report the pathological (objective) conditions that you have by examination found underlying or explaining symptoms that you have verified.

(3.) Any study of a drug, or symptom, or group, will be of value in stimulating interest in Materia Medica. Send such to us or present it in the Bureau of Materia Medica.

Dr. Pierce brackets clinical symptoms, the others are from Allen's Handbook.

### AGARICUS.

DR. PIERCE: Frequent twitching of different muscles (only when awake, quiet during sleep. Two cases of chorea cured).

DR. SEITZ: Involuntary, irregular movements while awake, ceased during sleep. Twice in chorea.

DR. BEDFORD: Twitching of eye and eyeball. Headache.

JOHN L. MOFFAT: Eyes burn and itch. Twitching in the eyelids, in the eyeballs. Redness, burning, itching of the ears or toes as if they had been frozen.

ALUMINA.

DR. SEITZ: Dryness of mucous membrane of rectum.

DR. BEDFORD: Dry, scant stool. Was of some benefit in lead paralysis of right arm and wrist.

DR. MOFFAT: Inactivity and weakness of rectum, even the soft stool requires straining. Constipation of nursing children. Profuse, acrid, transparent mucus, leucorrhœa.

AMMONIUM CARB.

DR. SEITZ: Putrid sore throat, dark red.

DR. BEDFORD: Dry cough, worse at 3 a. m., with weak heart.

DR. MOFFAT: Violent cough, worse at 3 or 4 a. m. Unable to speak aloud, difficult breathing. Sensitiveness to the air.

ARGENTUM NITRICUM.

DR. PIERCE: (In new-born infants, purulent) ophthalmia with pain, photophobia (profuse discharge and) agglutination of lids (after sleeping). Redness, congestion (inflammation) of fauces (with) sensation of splinter in throat when swallowing. (The severity of the sticking pain the guide for selecting this remedy.) Craving for sweets (which cause great distension and much noisy eructation). (Indigestion with great) distension; violent eructations (free eructations, without effort, rolling up in volumes with noise, without especial relief). Diarrhœa, green mucus, watery (flaked with green), with noisy emissions of flatus; stool discharged with much spluttering).

DR. DOWLING (ALLEN): *Eyes* blood-shot, in morning filled with mucus. Photophobia with smarting and burning. Itching in lids with lachrymation, agglutination, blurring of vision when reading. *Ears.* Stitches in ears, whizzing in ear, with hard hearing; ringing with deafness. *Throat.* Congestion of pharynx; mucus in morning; hard lumps, causing hawking and retching. *Urethra.* Cutting pain on urinating. Thick discharge, somewhat bloody.

DR. SEITZ: Conjunctiva inflamed, red, raw, profuse discharge. Same in throat.

DR. BEDFORD: Great flatulence. Frightful dreams of snakes. Heaviness of lower extremities.

DR. MOFFAT: Intense headache. Purulent ophthalmia. Conjunctiva red, swollen, with profuse, thick, purulent discharge. Pain in eyes. Photophobia. Lids swollen. Desire for and results from candy. Eructations. Green stools with noisy flatus. Acne°.

BISMUTH.

DR. PIERCE: (Gastralgia with severe pain extending backward from region of stomach. Verified many times.)

DR. DOWLING: Stomach. Discomfort. Eructations bitter. Tenderness of epigastrium. Abdomen. Rumbling with eructations. Flatus.

DR. SEITZ: Discomfort after eating. Eructation of small particles of food. Seldom vomiting.

DR. BEDFORD: Gastric irritability with diarrhœa.

CARBO VEG.

DR. PIERCE: (Frequent nose bleed due to varicose veins on the septum.) (Flatulent dyspepsia, stomach swollen like a drum; the distress comes on an hour after eating.) The simplest food distresses. (Eructations difficult but afford great relief.) Offensive flatus (gives great relief when passed).

DR. DOWLING: Stomach. Hungry with aversion to food. Anorexia, coated tongue and eructations. Violent eructations, sour, bitter or tasteless. Griping wind colic. Tongue coated white. Abdomen: Distension, rumbling.

DR. SEITZ: Immense accumulation of gas, especially in stomach, belches. Whooping cough, cold sweat, cold skin. Collapse from heart disease, coldness, desire for air, face green; palliative only.

DR. BEDFORD: Sour eructations with flatulence. Epistaxis, chronic bronchial cough.

DR. MOFFAT: Eructations and hoarseness with burning in throat and stomach. Vital forces nearly exhausted, collapse in pneumonia with weak heart. Has saved life when whiskey failed.

CAULOPHYLLUM.

DR. DOWLING: Rheumatic pains in small joints, worse at night, with redness and stiffness. Stiffness of fingers. °Delayed and feeble labor pains. Has acted as powerfully as ergot at times.

DR. SEITZ: Flying pains in small joints.

DR. BEDFORD: Rheumatism of small joints. Inefficient labor pains.

DR. COCHRANE: Rheumatism of small joints in women.

DR. MOFFAT: Dysmenorrhœa, spasmodic pains (cramps) in or across the hypogastrium. Rheumatism of the small joints. Fingers very stiff.

CARBOLIC ACID POISONING.

DR. COCHRANE contributes this case: A brakeman, aged 45, crushed his hand coupling cars. Six stitches were taken and the rest of the wound allowed to granulate. The wound was cleansed with carbolic acid, about 1 to 500. Dressing, iodoform and gauze. The following day the back of hand, especially between fingers, was covered with a vesicular eruption on a red base, (vesicles later developed into pustules,) itching and burning intense. Calendula ointment had a soothing and curative effect; wound was cleansed daily after this with bi-chloride and the skin eruption disappeared in a few days. A weak solution of carbolic was inadvertently used a week later, causing a reappearance of the eruption, which subsided under calendula ointment. The patient said that a somewhat similar experience occurred to him fifteen years before, when his hand was dressed after an injury.

Respectfully submitted for the Committee,

JOHN L. MOFFAT, *Chairman.*

## REPORT OF THE PRESS COMMITTEE.

DR. JOSEPH T. COOK, for the Press Committee, reported that the Society had appointed this year a press committee representing twenty different towns of the State of New York, and as Chairman of that Committee, he (the speaker) had communicated with each of those members and skeleton newspaper notices had been sent to each of them at intervals with the request that they prepare duplicate copies and have advance notices of the meeting published in their local papers and those of adjoining towns. Very many of the members of the Committee had responded favorably to that request, and the results warranted the efforts put forth, as these advance notices must be helpful to the cause of homœopathy and indirectly to the members practicing in the various districts. While the response had not been complete, it was sufficiently good to encourage the speaker to feel that the general good to the cause throughout the State would be noticeable.

On motion, duly seconded, the report was adopted.

## REPORT OF THE COMMITTEE ON INCREASING MEMBERSHIP.

DR. GEORGE R. CRITCHLOW, for the Committee on Increasing Membership reported that this committee was of recent origin, and

therefore the report must be somewhat fragmentary. A committee had been appointed representing the geographical sections of the State, each member thereof appointing a sub-committee for local work. It was hoped thereby to reach every member of the homœopathic profession in the State who was not already a member of the Society. The work was progressing at a good rate, and they hoped at the annual meeting to report numerous applications for membership. A special effort was being made to reach those who some years ago had dropped out of the Society for one reason or another, and who would now doubtless be willing to return to the fold.

## REPORT OF THE COMMITTEE ON LIFE INSURANCE.

DR. GEORGE R. STEARNS: Mr. President, in regard to the appointment of homœopaths by the large insurance companies as examiners, Dr. Zwetsch informed me yesterday that he had only just received the announcement of his appointment as examiner for the Mutual Life of New York, the first homœopath who had received such an appointment by that company. Dr. Zwetsch already holds a position in the Aetna and in the Equitable; and we were just now discussing informally the fact that all the talk and resolutions we can bring before the societies will have very little weight with these companies in comparison with the argument of having our patrons, when they are approached by agents to be written up, say that if they can be examined by their family physician they will take the policy, otherwise they will go to some other company who have homœopaths on their list of examiners. The Equitable has treated our school very courteously, and has recently appointed, I understand, eight examiners from the homœopathic school in Western New York as regular examiners for the company. The Mutual Life, as I say, has been more conservative, and Dr. Zwetsch is the first representative of our school to be appointed by that company. His appointment was entirely unsolicited, and the argument used was the handling of a $200,000 policy, which he very skillfully landed for the Equitable in the face of a very strong opposition and the hardest sort of work on the part of the Mutual, showing that his influence was sufficient to take the policy from the Mutual representative and land it in the Equitable, in which he was an examiner. This awoke them to the fact that he was a responsible man, and his credentials were evidently sufficient, and the appointment has come. That is the argument we must use all the way through. (Applause.) When we are approached by agents, for ourselves or our patients, let us ask the question, "Who are your examiners?" They will mention such and such individuals. "Have you any homœopaths?" "We have not." "Very well, there are other companies just as good as yours who have homœopaths." We do not ask it to buy an appointment. That is not the argument I wish to make at all. I wish to represent simply that there are wealthy men, representative of the community and its wealth, among our patrons, and we can use our influence in

turning them to companies who are not so conservative as to bar out a man simply because he is a homœopath, but make the appointments on the ground of the credentials of the man himself. With that argument I think we can carry the fight on successfully without any question whatever.

DR. GARNSEY stated that the Northwestern Mutual was very favorable toward homœopaths, as he (the speaker) had been an examiner for that company for the last twenty years. The two old-school physicians who were in the field when he began were practically retired, and he had the field in his city for that company.

DR. FAUST said he had represented the Phœnix Mutual Life of Hartford for the last three years, and the appointment had come entirely unsolicited. There was another old-school examiner in the same field, but the speaker was now getting the big end of the business, notwithstanding that the county society, at the instigation of his old-school brother, had passed resolutions and forwarded them to the company reciting that the speaker was a homœopath, a young man, that he lived in a house that was rented and not owned by him, and that for other "suitable" reasons the old-school physician ought to have the business. Nevertheless, he was still a homœopath, had got the house, and had the business.

One of the members pointed out that from a personal acquaintance with Dr. Morgan, of the Phœnix Mutual Life, and with his family, he knew that that gentleman was decidedly averse to having anything to do with homœopaths, and would do everything in his power to prevent their appointment. He thought there must be some personal influence existing to make an exception of Dr. Faust.

DR. FAUST replied that Dr. Morgan had stated to him in private correspondence that he did not care whether a man was a homœopath, an allopath or an osteopath, as long as he knew physical diagnosis.

PRESIDENT GREENLEAF: You have been examining for the company, not for the applicants. That makes a great deal of difference.

DR. ZWETSCH, of Gowanda, said the smaller companies had been appointing homœopaths for the last fifteen years. The John Hancock, the Equitable Life, the New York Life and the Mutual Life had not. The New York Life had not a homœopath on its staff in the United States. The Buffalo agent of the John Hancock Company had written to Dr. Bliss at Boston asking for the speaker's appointment, as he wanted his influence in some large policies. Dr. Bliss had replied saying he would not appoint a homœopath. The agent then wrote saying he could not get these policies. Finally Dr. Bliss wrote to the speaker inquiring whether the agent had been promised the policy if the appointment were made, to which the speaker had replied, "I guess you don't understand the homœopathic physicians. You can't buy them so cheap,"—that he could go to h——, and he (the speaker) would have nothing more to do with it. Since that they had written to him again. They had done no business in his locality since, and he did not think they would. The

John Hancock and the New York Life were the only companies that did not appoint homœopaths to-day. The speaker mentioned a number of instances in which his influence with intending insurers had come under the notice of the various companies in question, as a result of which he had been appointed examiner by the Equitable and the Mutual Life. Mr. Tarbell, Vice-President of the Equitable Life, was in Buffalo to-day, and had just informed the speaker that they had appointed eight homœopathic examiners in Western New York in the last two years. After a man had been appointed by one of those four large companies, it was easier to get an appointment from the others. He had been asked to examine an individual case for the Vermont Mutual, they knowing he was a homœopath, and had been offered the appointment for the Prudential.

A member said he wished to correct the statement regarding the New York Life. He had been an examiner for that company for five or six years, and his partner was also an examiner for them.

DR. FAUST thought it would be well for the Society to send out inquiries by mail to the members to ascertain who were examiners. He thought it possible that there were a lot of members of the Society examining for companies that the others did not know about.

DR. STEARNS said he thought he would act on that suggestion and endeavor to report at the February meeting.

SECRETARY WILCOX pointed out that although these examiners were now practicing homœopathy, they, in some cases, might have received the appointment because of having been formerly graduated from the old school.

DR. LANE suggested that the inquiry to be made should also bring out the fact as to whether one had been rejected by any company because of being a homœopath. The Vermont National had rejected him for that reason.

DR. WARD thought the old-line companies would not appoint a homœopath where they thought an old-school man would serve them nearly as well. The homœopaths had the lead among the better class of practice in Binghamton, and the local agents were eager to have homœopathic examiners appointed, as they realized it would be of advantage to their business. He (the speaker) knew some of the examiners very well, some were his patients, and they all assured him that it was absolutely impossible to secure the appointment of a homœopath, owing to the policy of the company being against it. He believed homœopaths should use their influence upon the agents. The mere fact of an isolated appointment of a man who happened to have a special pull in one of the smaller towns, did not prove that the school at large was given the same fair treatment. He believed that in the larger cities the best men were not getting these appointments, but were being turned down.

DR. ZWETSCH thought the Binghamton agents were to blame. He thought they did not push these homœopathic appointments. He knew that to be a fact. When there was a homœopathic patron that wanted a large policy, that was the time to take the matter up.

The more the companies felt the influence of the homœopaths upon their business, the more readily they would recognize the school.

DR. HOWLAND said that Binghamton was a beautiful town, but in Elmira they were fighters. All the examining for the United States Army there had been done by homœopaths for the last three years. Elsewhere homœopathy was not recognized by the United States Army at all. It was hardly recognized in the National Guard. At the time of the Spanish War there were a few homœopaths who took the examinations and were admitted to the army, and since their return all the examinations in Elmira were made by homœopaths.

DR. COLE agreed with the last speaker in that much of the trouble arose from the fact that they were not fighters. It was possible that in Hartford and throughout New England, people adhered more tenaciously to precedent, and were not so progressive, but they were improving, and he would suggest this action to physicians throughout Connecticut at their state meeting, to see if they could not stir up a little more enthusiasm.

PRESIDENT GREENLEAF said they had one or two war horses in the Western New York Society, and they knew when to call on them, and the work was done.

## REPORT OF THE COMMITTEE ON ATTENDANCE.

Enrolled the following 115:

*Albany County*—A. B. Van Loon, Joseph I. Dowling.—2.

*Allegany County*—Bemsley Williamson.—1.

*Broome County*—J. B. Bates, L. A. Martin, G. H. Jenkins, T. S. Turner, C. A. Ward.—5.

*Cattaraugus County*—J. D. Zwetsch.—1.

*Cayuga County*—Charles A. Gwynn, William M. Gwynn.—2.

*Chautauqua County*—M. M. Frye, Joseph Rieger.—2.

*Chemung County*—Reeve B. Howland, Frank H. DeCamp.—2.

*Chenango County*—C. N. Guy.—1.

*Columbia County*—Charles L. Mosher.—1.

*Dutchess County*—C. E. Lane.—1.

*Erie County*—George R. Stearns, D. G. Wilcox, Fred D. Lewis, D. H. Arthur, John Miller, F. B. Seitz, William E. Long, Clayton W. Seaman, George F. Adams, F. Park Lewis, J. T. Cook, George R. Critchlow, B. J. Maycock, John G. Chadwick.—14.

*Fulton County*—W. S. Garnsey.—1.

*Genesee County*—J. W. LeSeur, H. S. Hutchins.—2.

*Jefferson County*—W. H. Nickelson.—1.

*Kings County*—R. H. Stolz, H. P. Schenck, J. L. Moffat, William L. Love, W. B. Winchell, W. M. L. Fiske, Helene S. Lassen.—7.

*Livingston County*—B. P. Andrews.—1.

*Madison County*—George W. Wilcox.—1.

*Monroe County*—W. A. Keegan, Shirley R. Snow, Charles R. Clapp, E. J. Bissell, E. J. Whittleton, Myron H. Adams, Llewellyn J. Sanders, George M. Haywood, Edwin H. Wolcott, Newton M. Collins, Marcena S. Ricker, H. W. Hoyt, C. R. Sumner.—13.

*New York County*—Alfred Drury, B. G. Clark, Emily C. Charles, L. L. Danforth, G. F. Laidlaw, J. T. Simonson, Walter G. Crump, G. W. Roberts, F. W. Hamlin, J. Oscoe Chase, William H. Van den Burg, A. Berghaus, H. M. Dearborn.—13.

*Niagara County*—S. W. Hurd.—1.

*Oneida County*—A. R. Grant, C. T. Haines, M. O. Terry.—3.

*Onondaga County*—J. W. Candee, J. W. Sheldon, W. L. Hartman, B. W. Sherwood.—4.

*Ontario County*—F. P. Warner, C. A. Rowley.—2.

*Orleans County*—Myra A. Gillette, Emily F. Swett.—2.

*Orange County*—D. Henry Chandler, Robert C. Woodman.—2.

*St. Lawrence County*—Frank F. Williams.—1.

*Schenectady County*—William P. Faust.—1.

*Steuben County*—A. H. Rodgers.—1.

*Sullivan County*—Howard P. Deady.—1.

*Tioga County*—H. E. Merriam, J. T. Greenleaf.—2.

*Tompkins County*—Martin Besemer.—1.

*Washington County*—D. E. Spoor.—1.

*Wayne County*—E. P. Thatcher.—1.

*Westchester County*—D. J. Roberts, R. R. Trotter.—2.

*Wyoming County*—W. B. Gifford.—1.

*Visiting Physicians*—H. B. Besemer, Ithaca; Daniel B. Jewett, Rochester; Mark E. Reed, Buffalo; L. M. Andrews, Pike; W. S. Trimmer, Livonia; W. J. Hardy, Belmont; W. A. Dewey, Ann Arbor, Mich.; C. E. Sawyer, Marion, Ohio; W. H. Vosburg, Dunkirk; A. Grace White, Bradford, Pa.; C. V. Webb, Bridgeport, Ct.; A. M. Whiton, South Byron, N. Y.; F. D. Parker, Akron, N. Y.; W. H. Cole, Hartford, Ct.; F. B. Groesbeck, Buffalo; G. H. Smith, Brooklyn; F. W. Bentley, N. Tonawanda; M. E. Campbell, Rochester.—18.

## THE REPORT OF THE BOARD OF CENSORS.

Elected the following 11, all of whom were elected permanent members:

| | ENDORSERS. |
|---|---|
| FRANK H. DECAMP, Horseheads, I, '92, . . | F. W. Adriance, R. B. Howland. |
| F. W. SEWARD, Jr., Goshen, I, '98, . . . | H. M. Dearborn, John T. Greenleaf. |
| W. J. HARDY, Belmont, I, '89, . . . . . | G. H. Jenkins, B. Williamson. |
| CARL A. BLACKLEY, Lockport, III, '96, . . | S. Wright Hurd, G. R. Critchlow. |
| J. T. SIMONSON, New York City, I, 1901, . . | G. H. Laidlaw, DeWitt G. Wilcox. |
| BRADFORD WYCKOFF SHERWOOD, A. M., Syracuse, III, '90, . . . . . | W. C. DuBois, W. H. Nickelson. |
| WM. M. GWYNN, Auburn, III, '67, . . . | J. W. Sheldon, J. Willis Candee. |
| R. L. MCGEOCH, Goshen, I, '94, . . . . | H. E. Merriam, F. W. Seward. |
| CHARLES R. CLAPP, A. M., IV. '87, . . . | C. R. Sumner, Marcena S. Ricker. |
| LOUIS G. NEWMAN, Brewster, I, '95, . . . | L. J. Sanders, Wm. P. Faust. |
| CLEMENT N. GUY, Greene, IV, '83, . . . | John T. Greenleaf, L. A. Martin. |

## MISCELLANEOUS BUSINESS.

DR. MAYCOCK, on behalf of the local committee, announced that at a quarter of eight on Wednesday evening the members of the Society and ladies accompanying them, as well as physicians present as guests of the Society, were invited to a dinner, as guests of the physicians of Western New York, at the Stadium restaurant, Pan-American Exposition grounds, and that later in the evening a special performance would be given, beginning at 10 o'clock, for members of the Society and guests only, at the theatre of the Streets of Cairo, for which reduced rates had been obtained.

DR. GIFFORD announced that the Streets of Mexico had also accorded a special rate of fifty cents for the bull fight.

Dr. Greenleaf read the following, offered as a standing resolution, which was adopted:

### STANDING RESOLUTION.

*Resolved*, That any former member of this Society, who has resigned therefrom in good standing with the Society, may be reinstated upon his request, by making out and presenting the usual application, without paying the initiation fee, when such application has been approved by the censors.

The foregoing is approved and recommended by the Executive Committee.

J. T. GREENLEAF,
DEWITT G. WILCOX,
C. T. HAINES,
W. B. GIFFORD,
EDWARD G. COX.

A committee consisting of W. B. Gifford, John L. Moffat and F. Park Lewis was appointed to draft resolutions with regard to the death of President McKinley. They reported the following resolution:

The Homœopathic Medical Society of the State of New York, assembled in Buffalo, September 26, 1901,

*Resolves*, That we share the horror of the civilized world at the dastardly assassination of President McKinley, and respectfully tender our sincere sympathy and condolences with his bereaved widow.

His great work is but seemingly interrupted, his dying bequest will ensure its accomplishment.

William McKinley ever grew with occasion and showed himself to be a truly great leader by always being just enough ahead of the times not to lose touch with them. (Signed.)

W. B. GIFFORD,
JOHN L. MOFFAT,
F. PARK LEWIS.

The following program was carried out:

FIRST DAY.—MORNING SESSION.

**BUREAU OF OPHTHALMOLOGY AND OTOLOGY.**

DR. ALTON G. WARNER, Chairman, absent; DR. F. PARK LEWIS took charge. Two papers presented.

"The Effect of Tobacco on the Eyes," by F. PARK LEWIS.

"Some Remedies for Otorrhœa," by JOHN L. MOFFAT.

**BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.**

DR. C. A. WARD, Chairman, presented four papers:

"Clinical Excerpts of Echinacea," by W. H. NICKLESON.

"The Treatment of Oedema," by G. F. LAIDLAW.

"Infantile Scurvy," by GEORGE H. JENKINS.

"Alopecia Areata," by WILLIAM L. LOVE.

**BUREAU OF PÆDIATRICS.**

DR. H. E. MERRIAM, Chairman, presented two papers:

"Ileocolitis," by JOHN G. CHADWICK.

"The Child's Liver," by H. E. MERRIAM.

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SECOND DAY.—MORNING SESSION.

**BUREAU OF LARYNGOLOGY AND RHINOLOGY.**

DR. H. W. HOYT, Chairman, presented one paper.

"Etiology, Symptomatology and Diagnosis of Tuberculosis of Larynx," by J. H. HALLOCK. Discussed by FRED D. LEWIS.

**BUREAU OF MATERIA MEDICA.**

DR. WALTER T. CRUMP, Chairman, presented one paper.

"Study of a Heart Remedy," by THOMAS C. DUNCAN.

Special subject for dicussion:: "How, as a society, shall we systematize the various efforts to improve our Materia Medica and how conduct future provings that we may meet the demands of modern science?"

**BUREAU OF SURGERY.**

DR. HOMER I. OSTROM, Chairman, absent; DR. DEWITT G. WILCOX took charge. Four papers presented.

"Surgery of the Ileo-cæcal Region," by A. B. VAN LOON.

"Care of the Intestinal Canal Before and After Operations," by SHIRLEY R. SNOW.

"Where the Discrepancy?" by C. E. SAWYER, Marion, O.

"Weak Foot: the Cause and Treatment," by H. P. COLE, Hartford, Conn.

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## THIRD DAY.—MORNING SESSION.

### BUREAU OF GYNÆCOLOGY.

DR. GEORGE W. ROBERTS, Chairman, presented three papers:

"Sterility and Fecundity," by DEWITT G. WILCOX.

"A Report of Some Clinical Cases," by M. BELLE BROWN.

"Sexual Neurasthenia," by A. R. GRANT.

### BUREAU OF NEUROLOGY.

DR. GEORGE F. ADAMS, Chairman, presented one paper.

"Spiritualized Food for Mental Invalids," by SELDON H. TALCOTT.

### BUREAU OF OBSTETRICS.

DR. FRANK W. ADRIANCE, Chairman, absent; DR. HOWLAND took charge. Three papers presented.

"Experience with Oxygen in the Resuscitation of a New Born Infant," by J. W. SHELDON.

"Douching," by A. LENORA WHITE. (By title.)

"Acetate of Copper as an Oxytocic," by GEORGE F. LAIDLAW.

"A Case," by BEMSLEY WILLIAMSON.

### BUREAU OF PUBLIC HEALTH.

DR. HOWARD P. DEADY, Chairman, presented two papers.

"Dangers of Climates and Health Resorts," by BUSHROD W. JAMES, Philadelphia, Pa.

"Koch's New Theory of Bovine Infection in Tuberculosis," by WM. H. VAN DEN BURG.

# REPORT

OF THE

## BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

"The Effect of Tobacco on the Eyes," - - - - F. PARK LEWIS.
"Some Remedies for Otorrhœa," - - - - JOHN L. MOFFAT.

## THE EFFECT OF TOBACCO ON THE EYES.

F. PARK LEWIS,
BUFFALO.

For more than a century the fact has been recognized that under certain conditions tobacco taken into the system exercised a pernicious effect upon the eyes. During the last thirty years the subject has been studied with great care. Yet, although smoking is almost universal and the opportunities for observation practically unlimited, although there is no toxic substance so commonly and regularly consumed by mankind unless it be coffee, our exact knowledge concerning its pathogenetic effect has been by no means accurately ascertained.

It was the intention of the writer to present some notes on the rather unusual effects of this drug, with the intention of adding to a discriminating knowledge of its morbific influence on the eye, but a careful study of the problem as it presents itself demonstrated two exceedingly interesting and important facts that have seemingly been overlooked in our previous studies of this question.

We have learned that among the enormous number of smokers a very small proportion become amblyopic. Hirschberg's statistics say 0.6% of the whole number of cases "during sixteen years of a rich clinical service"; says DeSchweintz, "Groenouw recorded 185 cases of intoxication amblyopia." In these cases, too, most of them were alcoholics, and no discrimination was made.

Among the Turks, with whom the amount of tobacco consumed is enormous, amblyopia is practically unknown. The Turks, on the other hand, are all well people, the least given to the use of alcohol. It is, indeed, forbidden by their religion. Now in view of the fact that alcohol alone will produce a condition of the optic nerves very similar to that which is ascribed to tobacco, we cannot escape the conclusion that the very small proportion of amblyopes, as compared with the large number of tobacco users would be still further reduced, if it were possible for us to discriminate and select those only who

were not given to the use of other intoxicants. A further fact which is of importance is this: among those who are users of tobacco, and who give evidence of disease of the optic nerve are those whose daily consumption of this substance is no greater or in some cases even less then is that of others whose vision remains unaffected.

This may be ascribed to idiosyncrasy. It is much more likely to be due to another cause to which no consideration has heretofore been given, but which cannot fail to have an important bearing. I refer to auto-toxic conditions already existing in the system and dependent upon other causes. It is a well known fact, though of recent acceptance, that many of the diseases of civilized life are due to a failure on the part of the system to maintain a normal balance in the increment and excretions; sedentary lives, excess in eating, persistent over draughts on the nervous energy prevent the establishment of that absolute equipoise that is essential to health. The blood becomes surcharged with toxicants that alone are sufficient to prevent the tissues of the body from receiving that nutriment essential to make them resist attack. A further toxic substance is persistently introduced.

The nerve centers in a special way are attacked by this latest poison, and we immediately assume that all of the nervous phenomena which are present are the result of the nicotine, or of some of the numerous piridine bases—it is immaterial—instead of being the result of the combined attack of the auto and extra toxic substances which are brought together in the body.

The importance of the bearing of this side of the subject will be at once apparent. We cannot make a discriminating analysis of a single case, until we shall first have learned whether or not arterio sclerosis be present, whether the elimination of urea is sufficient, whether the liver and lungs and skin are doing their work efficiently and thoroughly.

Therefore, most of the available studies are unsatisfactory and incomplete. They give gross lesions which are produced not only by tobacco, but by a series of toxic substances of which the tobacco, important as it is, is but one. If, then, we would study this subject carefully in the light of modern science, we must begin at an earlier stage with a more complete knowledge of our data, and finally, and this is the second point of importance, *with more accurate instrumentation.*

Until recently the perimeter has been a rarely used instrument in the usual ophthalmological outfit. This has been due to the fact that it has been so awkwardly constructed and so tedious in its manipulation, that only in those cases in which the field of vision was essential to a diagnosis was the time taken to make the necessary chart.

Moreover, a field of vision taken by daylight is not always perfectly accurate and entirely trustworthy, and not nearly as fine in detail as one taken in the dark. In the broad glare of the sunshine the number of diverting objects that are necessarily thrust in view, dis-

tract the attention from the one small colored spot by which the retinal perception is determined. The perimeter devised by Dr. Skeel has been so much improved in its mechanism, however, that one single further modification will make it of great value not only for pathological but for physiological investigation.

In this instrument upon a black semi-circular revolving band is placed a disc having square openings of 5 and 10 mm. respectively which may be illuminated at will by an electric light to give white, blue, red, green and yellow.

The improvement which the writer will suggest was first observed in the clinic of Dr. Wilbrandt in Hamburg. It is that the band be replaced by a hollow globe of dead black. The examination is to be made, of course, in a dark room with no other illumination than that which is shown through the square opening in the disc.

This will allow the widest expansion of the pupil and therefore the largest field. The rest given the retina by the darkness will increase the perceptive power to the largest degree. It will then be possible to make accurate analysis of the visual field such as will give valuable information concerning not only the retinal, but as well often of the brain and spine.

The writer is able at the present time therefore, to present only this preliminary note, with the hope, however, that later, with a fuller knowledge of the general pathology, a clearer discrimination of the toxæmias present and a finer instrumentation, it may be his pleasure to make some studies of that form of toxic amblyopic tobacco, that only have a scientific value.

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## DISCUSSION.

JOHN L. MOFFAT: Dr. Lewis's improvement of Skeel's perimeter strikes me as the nearest approach to perfection yet attained; except—how can I be sure my patient's eye is constantly steady if it be at the center of a hollow hemisphere in a dark room? His omission of any description of the point of fixation must be an inadvertence; of course there is such a point. As to tobacco amblyopia; in twenty years I have had a few—I do not think half a dozen—cases in patients who denied alcohol; but I cannot recollect a single case attributable to alcohol without tobacco. An apparently healthy man, over seventy years old, stopped tobacco entirely upon my direction on account of amblyopia. He had smoked and chewed since boyhood, stood the change fairly well, but in about three weeks suddenly died of heart failure. In my experience patients will not give up tobacco gradually; they must do so at once or we will fail to check their amblyopia. There is great force in Dr. Lewis's suggestion,—which I endorse,—that every case of toxic amblyopia should have a thorough examination as to elimination (urea, sulphates, phosphates, chlorides, peptonuria, etc.), and the condition of the liver, bowels, etc. Query: Is not the exclusivist more apt to neglect this than the specialist?

DR. SCHENCK: In connection with what has been said about nicotine amblyopia, it might be interesting to mention an investigation under the auspices of the "London Lancet," undertaken by chemists and carried over some months of time, by which it was determined, by physiological tests, as well as chemical tests, that nicotine was comparatively harmless, and that pyridin was the insoluble substance that was the basis of the tobacco poisoning.

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# SOME REMEDIES FOR OTORRHŒA.

JOHN L. MOFFAT, M. D., O. ET A. CHIR.
BROOKLYN.

When aural suppuration is once established, of course surgical procedures must be employed,—free vent for the pus, removal of necrotic tissue, asepsis, and *dryness* of the parts. (To prevent suppuration the prolonged application of cold, sometimes of heat, and often a free incision are invaluable measures.)

The profession has run the gamut in the treatment of acute and chronic otorrhœa, from internal medication without even examining the ear, down, or maybe up, to entire reliance upon local treatments and operations.

Happily, both these extremes are about to pass, and aurists are coming to the recognition that internal medication is as essential in otology as in the treatment of other organs. The tissues of the ear are as susceptible to drug action as are the similar tissues of other parts of the body.

Local treatments or operative measures enable the internal remedy to act more promptly and efficaciously; but, on the other hand, the proper medicine will ensure rapidity and permanence of the beneficial effects of an operation. As in surgery generally, an operation does not cure—it merely puts the part of the body involved into a more favorable condition for recovery, which may then be either spontaneous or aided by internal medication.

In August, 1892, a boy, ten years old, came to me for otitis media suppurativa dextra of seven years' standing; there was a large perforation of the membrana tympani and a profuse, offensive, bloody, thick, yellowish discharge. Operation was out of the question, as he was white and anasarcous from so bad a mitral insufficiency that it did not seem possible for him to recover. (Hydrogen dioxid was used to keep the ear as clean as possible, and the main reliance was placed upon internal medication, his principle remedies being tellurium, kali sulph., kali phos., elaps and ars. iod.) Progress was satisfactory but slow; slight recurrences requiring occasional attention at intervals of months for a couple of years, when he finally

called himself well. Bryonia, arsenic and gelsemium were necessary at times and at last cardiac compensation was so well established that he experienced no bad effects from playing the violin and riding a bicycle.

Chronic purulent otitis media does not get well spontaneously, nor is hydrogen dioxid locally sufficient in itself to cure it.

As to adjuvants, I have had the best results with hydrogen dioxid, electrozone, pyoktanin blue (in fresh solution), formalin, bichloride, and succus calendulæ; wiping the accessible parts dry, and sometimes a light dusting of powdered boric acid or of calendulated boric acid. Each has failed, and each has proven efficacious when others failed.

INTERNALLY.

*Pulsatilla* is good for profuse, bland, thick yellow or yellowish-green muco-purulent discharge or pus. There may be itching deep in the ear, or vertigo, maybe nausea. Pains violent, as if something were forcing outward, or darting, tearing and pulsating. Deafness and roaring. Aggravation from warmth, in the evening till midnight. Relief by cool air.

This remedy is especially useful in negroes and children; after scarlatina; in acute cases, before or just after the appearance of a discharge.

*Hepar* (calcium sulphide) is the first remedy usually thought of for acute or chronic suppuration, but is not always the right one. Give it for a fetid, thick, purulent discharge with great sensitiveness to touch, and ready bleeding. Relief from warmth—from wrapping the head warmly. There may or may not be pains in the ears; if present they are sharp.

The patient is probably irritable, with hasty speech and actions; he is sensitive to the open air, feels cold when others present do not. Hepar follows pulsatilla well, and is especially useful if the patient has taken a great deal of mercury. If given in material doses (one-tenth grain) too soon it will probably precipitate a suppuration that might otherwise have been avoided.

Dr. H. P. Bellows gives hepar if the pain continues, and the discharge seems inadequate, after incision, or spontaneous perforation of the drum head, the leading indication being scanty discharge with localized tenderness.

*Mercurius* (solubilis or vivus) is suggested by pulsation of the pus at the inner end of the external auditory meatus. The discharge is thinner than under pulsatilla or hepar, is excoriating, bloody, offensive—may have a metallic or brassy odor. The pains are dull, constant, or stitching, tearing, with soreness or burning. The patient perspires much without relief, is worse from warmth and at night. Of course there is deafness. Sounds vibrate in the ears. The tinnitus is ringing and roaring, pulsating. Polypi.

*Silicea* is perhaps more frequently useful in persistent chronic otorrhœa than any other remedy, especially after operations and if the bone is affected. It promotes repair of the drum-head after suppuration has ceased.

The discharge is foul, thin, often scanty, or bloody. There may be sharp, drawing or stinging pains; hissing, singing or roaring tinnitus; itching in the ears, relieved by digging, scratching or cleansing the ears. With deafness, particularly for the voice, there is oversensitiveness to loud sounds. Relief by wrapping the head warmly. In a prolonged case it may be well to change for two or three weeks to lapis albus, which is the silico-fluoride of calcium.

*Tellurium* is very valuable, even if the odor of the discharge is simply offensive instead of like brine or fish pickle. The membrana tympani is dark purple with vesicles like phlyctenules, suppuration and perforation.

The discharge is thin, watery, very excoriating and irritating, causing redness and vesicles or pustules wherever it touches. The ear itches with painful throbbing in the external meatus.

*Kali phosphoricum.* Offensive acrid pus, dirty, brownish, watery. Deafness, blunted perceptive power. Tinnitus—humming, buzzing —with weakness and confusion.

*Kali sulphuricum.* Ear-ache with thin, yellow discharge. Sharp cutting pain under the ears; tensive, stitching pain under the mastoid process. Worse in heated room. Polypus in the meatus.

*Kali bichromicum,* stringy, ropy, yellow discharge, especially if associated with nasal catarrh or rheumatic pains in various parts of the body that alternate with nausea or indigestion. Indolent ulceration.

*Kali muriaticum,* chronic suppuration, stringy, white discharge. Abundant granulations or hypertrophied mucous membrane of the middle ear. The most valuable single remedy for the deafness following purulent or catarrhal otitis media.

*Elaps,* a thin, yellow green, maybe bloody discharge that is somewhat irritating; it stains the pillow-case clear green. The mucous membrane (especially of the naso-pharynx) may be cracked and dry.

*Psorinum* is to be given to patients subject to glandular and cutaneous affections who do not respond to the apparently indicated remedy. The obstinate otorrhœa is thin, ichorous and extremely offensive. There is an offensive odor to the whole body, and often itching.

*Thuja,* if the patient has had gonorrhœa or has been vaccinated. The discharge is bland and thick, smelling like putrid meat.

*Calcarea picricum* has been found useful for prolonged or recurrent cases with muscular weakness and want of will power.

Ars. iod., aurum, calc. phos., calc. iod., hydrastis, kali iod., lycopodium, mezereum, nitric acid, petroleum, and sulphur will also well repay study.

The condition of the naso-pharynx and eustachian tube must always be taken into account, and the totality of the symptoms should be covered if possible. An unexplainable and otherwise unimportant symptom may determine the choice of the successful remedy.

As hinted in the beginning of this paper, justice is not done to the patient if the practitioner neglects any measures that will conduce to a quicker and more permanent cure.

# REPORT

OF THE

## BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

"Clinical Excerpts of Echinacea," - - - W. H. NICKELSON.
"The Treatment of Oedema," - - - - G. F. LAIDLAW.
"Infantile Scurvy," - - - - - GEORGE H. JENKINS.
"Alopecia Areata," - - - - - - WILLIAM L. LOVE.

## CLINICAL EXCERPTS OF ECHINACEA.

W. H. NICKELSON,
ADAMS.

I have nothing new to offer in regard to the homœopathic proving of this most excellent remedy. The most extensive article on echin., that I have seen, will be found in our New York State Transactions for year 1898, written by J. Willis Candee, M. D., of Syracuse, N. Y., in which he says that we fail to find anything in echin. which would lead us to think of echin. in septicæmia. I have used it with such marked success in cases of septicæmia that the chairman of the Bureau of Clinical Medicine has requested me to give you my experience. In February, 1898, I confined Mrs. G., a primipara. On the night of the fifth day she had a slight chill. The nurse failed to send for me. The next day when making my regular calls, about eighteen hours after the chill, I found her temperature 105° and pulse 140. I gave ver. vir. $\theta$ and irrigated the vagina and uterus. Under this treatment the temperature had increased in six hours nearly one degree, or to 106. Verat. vir. $\theta$ was used for eighteen hours without any improvement or drop in the temperature, at which time the late Dr. W. T. Laird, of Watertown, saw the patient. There were no signs of local peritonitis, pelvic cellulitis, nutritis or mastitis and the lochia seemed normal.

Neither of us could account for the high temperature and rapid pulse unless it was due to septicæmia. Dr. Laird gave a very unfavorable prognosis. She was given echin. $\theta$, ten drops every three hours. The uterus was irrigated every six to eight hours and in twelve hours the temperature began to fall and in less than three days it was normal and my patient made a rapid recovery. In a few other puerperal cases where there has been any markable rise of the tempera-

ture I have used echin. always with good results, the temperature gradually falling to normal. I always feed these cases as much as possible and use every three to eight hours an inter-uterine irrigation, preferably permanganate of potash.

Dr. Joseph P. Cobb has a fine article on this branch of the treatment, in the Transactions of the American Institute of Homœopathy for the year 1900. I have never failed to see this remedy reduce the temperature and the patient to improve when the cause was septicæmia. Its action is not so marked when the condition is due to pyæmia.

In the suppurative stages of abscesses, carbuncles and the like it will reduce the fever, swelling and soreness and hasten the healing. I regret I have no characteristic symptoms to offer for the use of this remedy. I trust some accurate observer will soon find these symptoms and that the profession in the near future may be able to use this remedy scientifically in this most dreaded disease—namely, septicæmia.

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## DISCUSSION.

DR. HAMLIN: *Mr. Chairman*, for some time, that is to say, within the last two years, I have regarded echinacea and echifolta as the most valuable internal remedies which we have in the treatment of septic processes, and I think it is also very essential in using echinacea that we should get a reliable preparation of the drug. There is a great difference in the tinctures of echinacea. The one with which I have had the best success is made by Lloyd Bros., of Cincinnati. That is a dark green liquid, and with it I have had very good success in the treatment of septic processes; not only in the treatment of septicæmia itself, but also, as the doctor mentions, in the treatment of carbuncle and other septic affections.

There is another use of echinacea to which I would like to call attention, and that is in cases of perineal laceration where the healing is not perfect. During the last summer I have had several such cases, where, despite careful surgical work, the perineum failed to heal perfectly; perhaps would heal in part, and perhaps partly would slough out, leaving a ragged sore which was discharging pus. In all those cases it is my practice at the present time to use echinacea locally as a lotion and to give the patient echinacea internally. I use a teaspoonful of the tincture to a half glass of water, and give two teaspoonfuls of that every hour or two hours according to the severity of the case, and I must say that my results have been excellent with that treatment. During the last summer, also, I have had many cases of septic cellulitis, cellulitis caused by bites of insects or by scratches—infected wounds, in other words—and in those cases I have used echinacea very extensively during the last summer, and with excellent results. I regard echinacea as a most valuable addition to our materia medica, and I believe, notwithstanding the doc-

tor's statement that it has no effect in pyæmia, that it does have an effect on the production of pus.

CHAIRMAN WARD: The paper is now open for general discussion.

DR. G. F. LAIDLAW: *Mr. Chairman,* I dislike to see so good a friend of mine as echinacea going with so little notice. Like Dr. Hamlin, I was, perhaps, unfortunate in my first use in employing the preparation which I did, but I have succeeded so well with it that I have never dared to change it, because the cases in which you use echinacea are generally serious cases; they are septic cases, and I have hesitated to change a preparation with which I have succeeded for one which may be equally good, but with which I am unfamiliar. So I have stuck to the proprietary drug. I have seen it, as a local application, in suppurating wounds, reduce the swelling and take out the dark color, so that the wound changed from a dark, ugly, suppurating condition to a light colored, healthy, granulating surface, and I have found it to do that within twelve and twenty-four hours. In fact, the first case in which I saw it applied locally was after lancing a felon. Making a call at a patient's house, I was asked to see the servant girl, who had a bad finger, and I found she had had a felon lanced some five days before. It was on the index finger, the last phalanx. The last phalanx of the finger was swelled to about the size of a small plum, bluish red, with jagged openings extending along the whole length of the phalanx, and oozing pus. The patient had a slight rise of temperature and a slightly quickened pulse. There were no signs of general sepsis, but the finger was about as ugly looking a finger as you would want to see. Being somewhat in a hurry, and having read only that morning of the beneficial results of echinacea, I thought that finger would do till the next morning with a local application. I had her apply a drachm to an ounce of echinacea, in water, and the next morning I was surprised to see the swelling reduced one-half, the color entirely disappeared, that is, paled out to a healthy pink, and the whole condition turned into that of a healthy granulating wound. The phalanx of the finger stuck out so that it wobbled loosely; the phalanx had been detached at the joint, so that it practically came right out when you touched it. The finger went on and made a good recovery, of course with a somewhat disfiguring scar.

The writer of the paper mentions that we have no exact indication for echinacea. I am sorry that we have not. Our only indication is sepsis, which is too broad an indication to be successful in every instance; but I should hesitate to treat any septic condition with which I am now familiar without the aid of echinacea, without giving it at least forty-eight hours' trial. In puerperal sepsis I think I have seen it slower than in diphtheria, tonsillitis and septic cellulitis. Puerperal cases generally run about a week before the temperature comes down to normal. In diphtheritic cases it will often drop to normal in twenty-four hours. There is one thing to be guarded against in the use of echinacea. It acts something like the material anti-pyretics. It will often drive the temperature down

below normal a degree or half a degree, and it will often produce a condition that simulates collapse, the patient feeling faint and weak. The pulse becomes rapid and faint. That I have seen repeatedly with echinacea—I have never seen a patient get into a dangerous condition,—but I avoid doses of more than ten drops of this echifolta preparation, so as to be on the safe side, and have stimulants handy for nurses to give, in case any symptoms of collapse come on. But it is certainly a most valuable remedy for external and internal use in all conditions associated either with sepsis or with pus.

DR. J. T. SIMONSON: *Mr. Chairman,* I would like to ask one or two questions in regard to this drug. I tried it, I think, four or five times only, in septic conditions following labor. I have never gotten any results from it whatsoever. Dr. Laidlaw says we are obliged to wait four or five days or a week; but even after waiting pretty nearly that time my patients have seemed to get worse. I have never given the echifolta. That is a proprietary preparation. I have always given echinacea, as prepared by our homœopathic pharmacists in New York; and I think that as all the evidence as to the drug seems to be in favor of this echifolta, and not of the tincture echinacea, it would seem that there is a possibility that there is some constituent of the echifolta that is foreign to the echinacea. I have never tried the drug except in cases of puerperal sepsis, and my results have always been bad; that is, they have been nil, even when given according to the rules and in the way that is recommended by those who are familiar with the drug. I thought there might possibly be some contra-indication to it which I did not know, or that possibly there was some constituent of echifolta as prepared by Lloyd Bros., that was not found in echinacea as prepared by the homœopathic pharmacists.

DR. FAUST: *Mr. Chairman,* the experience I have had with echinacea has been diametrically opposite to that of Dr. Laidlaw. I first began using it to any great extent after the Syracuse meeting, when Dr. Candee, of Syracuse, if I am not mistaken, read a paper on this subject. Shortly after my return home I had occasion to use echinacea in a septic condition. I gave ten drop doses with apparently no results. I gave fifteen drop doses; I gave thirty drop doses; I gave a drachm; I gave two drachms every two hours, with the effect apparently that the temperature would come down partially, with no apparent result. The last year and a half I have employed a preparation of echinacea made by Merrill, of Cincinnati, who makes a line of normal tinctures, and this is one of their drugs, known as their normal tinctures; and using that preparation I have very seldom given more than fifteen drops of echinacea, and I have obtained results that I never got by using the ordinary homœpathic tincture, and I have used several of them.

DR. HAMLIN: I would like to add just one word, in response to Dr. Simonson,—that the preparation I have reference to is the tincture of echinacea alone, and not the preparation of echifolta,

which Dr. Laidlaw has referred to. The preparation I use is known as a specific tincture, and is put up by Lloyd Bros., as I say, the same people who manufacture the echifolta; but it is not echifolta; it is the tincture of echinacea.

DR. MOFFAT: *Mr. Chairman,* is it scientific to credit echinacea with curing puerperal sepsis when there had been also irrigation of the uterus? I have known a thorough irrigation of the uterus after curettement to bring the temperature right down, and I have known it to fail simply because it was not thorough. One of the speakers said that he had not had echinacea relieve puerperal septicæmia under a week. Had he tried it without irrigation when he came to that conclusion?

DR. LAIDLAW: *Mr. Chairman,* the cases I referred to were distant cases where I could not give irrigation personally, and no uterine irrigation was given. The amount of attention was limited. The echinacea probably was the active curative agent.

CHAIRMAN WARD: I might mention a paper written by Dr. Bullard, of Wilkesbarre, in which he spoke of getting very brilliant results with echinacea in cases of appendicitis, to prevent suppuration; not only when there was suppuration there, but beforehand.

DR. NICKELSON: I wish to state that in my case irrigation was used for eighteen hours with veratrum viride with no fall of temperature, and the temperature was continually rising. There was the same irrigation, and I did the irrigation myself so as to be sure that there was no difference in its use under the administration of the echinacea and before; and I began to get the fall of temperature within twelve hours. Dr. Candee, in his essay, explained that there are different kinds of echinacea, and that that which is grown in the East is not so reliable as that grown in the West. The echinacea I use is made by Luities, of St. Louis. That made by Lloyds, of Cincinnati, is probably the Western grown drug. If you are going to use a drug, use that which is grown in the right locality, as the man suggests who puts it forward, and do not get the drug grown in the East, because it is not produced under the same climatic influences as that which is grown in the West.

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# THE TREATMENT OF OEDEMA.

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I once treated an elderly man for general dropsy. The legs and abdomen and pleural cavities were full of water. There was œdema of the lungs. The heart presented a mitral lesion with hypertrophy. The urine was scanty, thick and highly albuminous,

only ten ounces being passed in twenty-four hours. He presented the bluish face, the anxiety, labored breathing and inability to lie down that forms the familiar picture of advanced œdematous conditions. The emaciation of the arms and chest indicated the dropsy to be of cardiac or hepatic origin rather than nephritic.

Before coming under my care, he had been treated by heart stimulation with strophanthus and free purgation with croton oil and elaterium. He had been referred to me for the purpose of tapping the enormously distended abdomen which had remained unrelieved by the copious watery discharges. The tapping was done, yielding six quarts of serous fluid and quickly relieving the dyspnœa and abdominal distress, though the patient still had a great deal of water in him.

As the purgation had been very vigorous and without effect, I gave him small doses of digitalis and nitroglycerin to steady a very weak and irregular heart action and, in addition, my favorite diuretic, the borotartrate of potash. Twenty-four hours of this treatment had no effect. The urine remained thick, dark and but little increased.

It is a maxim with me that an appropriate diuretic works quickly if at all. If in twenty-four, or, at most, forty-eight hours, the urine shows no increase, it is better to change the diuretic. Continuing the digitalis, I changed the borotartrate for a remedy that I first learned from Dr. Macy, of New York. It is a mixture of equal parts of the tincture of apis, apocynum and helleborus niger, of which ten drops is mixed with four ounces of water and a teaspoonful given every hour or so. The effect of this diuretic was prompt and satisfactory. Within six hours, the urine increased and became lighter in color. During the first twenty-four hours, the patient passed twenty-five ounces; during the next day, sixty ounces, and for several days thereafter more than a gallon a day. Meanwhile, his œdematous tissues shrunk in the customary manner, the transudates were absorbed from the cavities, albumin disappeared from the urine, sleep, appetite and strength returned and he was soon able to be about as a comfortable invalid. The mitral lesion remained and the pulse continued somewhat irregular but as far as the œdematous conditions were concerned, the work was done.

I shall make this case a text for some observations on the treatment of non-inflammatory œdema and serous effusion.

In the first place, non-inflammatory œdema is not a disease. It is a symptom. It is a symptom of evil import. It has a triple meaning. It means, first, that the kidneys are not excreting enough water; for, otherwise the œdema would not occur; secondly, that there is some disease of the capillaries and lymph-spaces of the affected part;* for, otherwise the œdematous transudation would not occur in that particular place; and, thirdly, that there is a relative

*Cohnheim proved experimentally that in artificial hydræmic œdema, when the kidneys and other glands refused to excrete the watery waste products, and the blood-vessels became filled with an excess of fluid, those parts became œdematous first whose function it is to excrete the water, and next those parts which had suffered injury, as traumatism or inflammation. *Virchow's Archiv, Band 69.*

decrease in the solid constituents or an increase in the watery part of the blood. Considering the influence of these three factors in the development and maintenance of œdema, it is easy to understand why our favorite diuretics so often fail, as mine did in the case cited. If the kidneys were a pair of faucets which simply required to be turned on when the reservoir was too full, the treatment of œdema would be a simple matter. But when our understanding of œdema comprises a disordered function in the kidney, a disordered function in the œdematous tissue and a disordered quality of the blood, we can understand that, for a diuretic to be effective, it must meet all of these conditions; its action must be three-fold. As the elements of renal insufficiency, lymphatic disorder and blood quality are probably seldom active in the same proportion in any two cases, we can understand why a diuretic which is strikingly curative in one case is totally inactive in another. We can understand why, with our imperfect symptomatic indications for one diuretic or another, we often fail to make that accurate adjustment of drug to disease which is necessary to effect the cure.

It is right here that homœopathy should come in to help us. What is there in medicine more sharply defined than the indications of our best known remedies? What system of medicine is so well adapted to make delicate adjustment of drug to disease? There is none. Shall we, therefore, discard diuretics as tools which we can use but clumsily and treat our œdematous patients by selecting the indicated remedy according to our present symptomatology? I think that I am correct in stating it to be the conviction of most homœopathic practitioners that this is not safe practice. Awkward as is our application of the material diuretic, we have nothing but the purgative, the Turkish bath, the trocar or the aspirating needle to take its place. Like hæmostatics, diuretics are emergency remedies. They relieve mechanical pressure, while the symptomatically chosen remedy can rarely be relied upon to do mechanical work.

Is the homœopathic remedy useless, then, in the treatment of œdema? By no means. Here must be drawn a distinction between palliation and cure. Diuretics palliate; they do not cure. It is possible that, after the diuretic relief of an œdema, the *vis medacatrix naturæ* may be sufficient to bring the patient's tissues back to the normal; but, in the majority of cases, this happy result will not be attained. Sooner or later, the œdema will return or another group of symptoms will appear, showing that the real disease is only lying latent ready to break out on slight provocation. The treatment of the underlying disorder is the sphere of the homœopathic remedy prescribed in close accordance with the symptomatology. It is here that patient study and waiting for curative results that are inevitably slow will find their tardy but grateful reward.

To return to the case of our text, you will recall that tapping became necessary. This proceeding not only relieves the oppressed breathing but favors the excretion of urine. It is known that for

the normal excretion of urine, a certain degree of intra-renal tension is requisite and that deviation above or below a narrow range interferes with the excretory process. It is probable that the increased intra-abdominal pressure of ascites increases the renal tension by pressure from without and that the simple act of relieving the abdominal distension takes that much pressure off the kidneys and permits them to resume their functions or to react to stimulating remedies that before were useless.

The next point in the text to notice is the utter uselessness of one diuretic of good reputation and the striking success of the other. The action of an appropriate diuretic is always striking and prompt. I know of no other rule for its selection. The selection must be somewhat haphazard and by their works you will know them.

Next, in the text case, we must notice the uselessness of purgatives. In the older text-books, they are universally recommended for dropsies and in the advice of more modern works it appears to be a matter of indifference whether the water is removed by the bowels, the skin or the kidneys. The only writer in whom I have found a decided opinion on this subject is Rademacher, who wrote in the early part of the last century. I translate as follows: "In the treatment of dropsy, purgatives that simply evacuate quantities of water from the bowels without increasing the urine are of little use; for the water accumulates again quickly. On the other hand, the slight irritation of the bowels, caused by a laxative, often increases the urinary flow. This action is uncertain but it is only in those cases of dropsy in which the purgative brings the disturbed urinary excretion back to the normal that the remedy is truly curative."

This observation is profoundly true. Since reading it about five years ago I have observed the course of dropsies more closely and can confirm Rademacher's statement by many instances, one of which is furnished by our text.

I am of the opinion that the same statement holds true of profuse sweating. No matter how much perspiration comes away, if the urine remains dark and scanty, no real benefit results.

Granting that the diuretic removes the water more effectually, does it weaken the patient more than purgation and sweating? If we can judge the patient's condition by his conscious strength, the advantage is on the side of the diuretic. Taking a more comprehensive view and disregarding the immediate good results, do we damage the patient ultimately by stimulating the kidneys in this manner? It is known that, under prolonged and frequent stimulation, a gland, like a muscle, tires and finally refuses to act. We must admit that the excretion of water by the kidney is not a mechanical filtration but a vital process. As such, it must require energy for its performance and, like other vital processes, it is subject to exhaustion and recuperates by rest.

Do we, with our diuretic, overwork the kidney tissue? Do we purchase present comfort at the risk of future kidney exhaustion

and thus shorten the patient's life? Is it not safer to purge the intestinal tract oftener and to let the kidneys alone?

This question is difficult of solution because we have no exact way of estimating vitality nor can we tell how long a patient might have lived if we had or had not given a certain diuretic or purgative. In endeavoring to solve this problem, I have made many urinary examinations of both nephritic and non-nephritic patients with the following results: excluding cases of nephritis, because here the action of the kidneys is subject to so many influences as to confuse the results, in all patients with œdema or a tendency thereto the urine is scanty, concentrated and generally dark in color. It always contains an abundance of mucous casts and usually hyaline or epithelial casts, pus corpuscles and a trace of albumin. When the urine is increased by a diuretic, the casts, corpuscles and albumin disappear. This is not simply the result of dilution of the urine; for I always examine the total urine for twenty-four hours and subject the sediment to powerful centrifugalization. The effect of a purgative which is not at the same time diuretic is the opposite. Both with spontaneous diarrhœa and medicinal purgation the urine decreases in quantity, concentrates, becomes darker in color and casts, pus corpuscles and a trace of albumin may then be found when they were not present before. It is evident, then, that the excretion of a large amount of diluted urine is less irritating to the kidney than a smaller amount of concentrated urine. It is evident that as far as visible damage to the kidney is concerned, the diuretic is less harmful than the purgative. At the same time it should be remembered that even the lightest work tires an organ if kept up continuously and that by using the diuretic for short periods with frequent intermissions, the interest of the patient appears to be best observed. It is also known that some diuretics damage an inflamed kidney by increasing the congestion already present. Such are squill, broom-tops, copaiba, apis and cantharis in material doses and, possibly, digitalis. In the presence of acute inflammation of the kidney, they must be used with caution.

Of the merits of the various diuretics, it is not my purpose to speak. I will only bring to your attention three old and little used remedies that are worthy of being better known.

The first is the borotartrate of potash or soluble cream of tartar. It is given in doses of a level teaspoonful in one-half glass of water repeated every three hours until a slight laxative effect is produced. Then the dose is regulated so as to secure about two loose passages daily. The second remedy is distilled quassia water, which Rademacher recommends in the ascites and œdema of chronic liver disease.*

The third medicine is acorn water, which cures dropsy dependent upon disease of the spleen.†

**Aqua Quassiæ.* Take twelve ounces of shavings of true quassia wood and two ounces of quassia bark. Macerate in four ounces of alcohol and sufficient water in a closed vessel for 48 hours. Then, with heat applied very gently at first, distill off two pints. Dose: ten drops to two drams.

†*Aqua glandium quercus.* One pound of crushed selected and succulent acorns are macerated in four ounces of alcohol and sufficient water to distill off two pints. Dose: five drops to two drams.

We all recognize liver, heart and kidney dropsies, but, except for the œdema of pressure of a much enlarged spleen, splenic dropsies are unfamiliar to us. Yet so acute an observer as Rademacher attributes one-third of all dropsies to spleen disease acting secondarily upon the kidneys. This is an old conception, far antedating Bright and his discoveries, and is mentioned in the Aphorisms of Hippocrates. It is a mistake to consider all knowledge of kidney diseases to have commenced with the work of Bright in 1827. The very patent relation between œdema and scanty urine taught the earliest observers that dropsy was in some way connected with kidney disease. The difference between the older notion and our modern one is this. Knowing the kidney lesions so well, we regard nearly all inflammatory kidney diseases as primary. The pre-Brightites thought that while the kidneys often became sick primarily, they were also subject to sympathetic or secondary disorders dependent upon liver, lung, brain, spleen or other local disease or constitutional disorder. Thus, in a plain case of congestion of the liver, if the urine was scanty and dark-colored, they considered it to be due to a sympathetic kidney disorder. If, during an evident splenic congestion, the urine, previously clear, became scanty and dark or if all local splenic discomfort disappeared but the urine remained cloudy or scanty or oedema developed, they reasoned that the disease had passed from the spleen to the kidneys, just as in rheumatic fever, the inflammation may subside in the knee-joint only to appear in the elbow.

The difference between the old thought and the new appears most strikingly in the principles of treatment. We search for drugs that affect the kidney tissue. We poison animals and examine them chemically and microscopically to find what changes are produced on the kidneys, and use the information gained in the treatment of just such urinary disorders as those mentioned. The older men learned that the medicines which they were accustomed to use as kidney remedies did not help these cases; but they found that under remedies adapted to the original liver or spleen symptoms, the urine increased, œdema disappeared and health was restored. We recognize this principle partially in our treatment of the kidney and liver disorders that develop during valvular diseases of the heart, which we treat with heart medicines, not with liver or kidney remedies. But these latter lesions are more in the nature of mechanical results than of shifting diseases in the ancient sense.

I must say that the behavior of some diseases, both acute and chronic, goes far to corroborate the ancient view. From the time of Bright and Rayer we have been dazzled too much by the exact researches of the dead-house. We have held up to view the large white kidney or the small red one and exclaimed triumphantly, "Behold it. There is the disease!" We have forgotten that that poor, distorted kidney is not the disease. *That is the end of it.* What long years of faulty chemistry of digestion, of disordered function of the skin or liver and what defective blood-making in the spleen

and bone-marrow have preceded these kidney lesions? These are questions that we are just beginning to ask ourselves and I am not sure but that these questions must be settled by study of the living rather than the dead. I am not sure but that, as we pursue these studies on the living, we will draw nearer to the long-forgotten conception of a kidney disorder that is sympathetic and secondary; one in which we must reach the kidney, not directly, but through the general organism: the liver, spleen or skin or other primarily affected tissue.

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## DISCUSSION.

*Mr. Chairman:* I wish first to thank Dr. Laidlaw for asking me to discuss a subject which emphasizes so distinctly in a well-defined class of cases the necessity for palliative treatment by the homœopathic physician. The members of our school of medicine seem to have a constitutional objection,—theoretically, at any rate,—to the use of such measures, considering them inconsistent with the true principles of homœopathy. This reluctance to use such remedial means is, I believe, frequently based on a misconception of the basic principles of homœopathy. In fact in the Organon—I believe in the third section—Hahnemann distinctly states that "The proper knowledge of curative medicine depends upon the application of what is curative in medicine to what is curable in disease."

Of course the question immediately arises as to what is and is not curable, but to the best of our knowledge at the present time extensive tissue changes render many of these cases absolutely incurable and I think we would be guilty of grave injustice to our patients if we withheld a diuretic which would afford, for the time being, at least, great relief.

Just here the sharp line of distinction drawn by the doctor between palliation and cure is a very important one. When in many of these cases of dropsy complicating heart or kidney disease the mechanical symptoms due to the presence of water in the tissues becomes distressing, I believe that the relief given by the action of a proper diuretic, or by tapping, if the effusion is abdominal, makes possible the action of a homœopathic remedy which was previously impossible; besides—even if the case is incurable—adding greatly to the comfort of a suffering patient.

The causes of dropsy enumerated by Dr. Laidlaw might, I think, be increased by two. First, the presence in the blood of an irritating substance (nature unknown) as in the various forms of nephritis; and second, changes in the composition of the blood itself, when as stated by Delafield, the quantity of urine may be normal or even much increased, and yet the dropsical condition gradually becomes worse. I have under treatment at present an old lady suffering from chronic nephritis in whom the dropsical condition is very marked, while the average daily amount of urine is between sixty and eighty ounces.

In such a case a diuretic is manifestly useless, the only chance of relief of the dropsy being through an improvement of the blood condition—and in improvement of the condition of the blood vessels. I know of no way of effecting this, if it is possible at all, except by the action of a drug homœopathically indicated.

As to the relative merits of sweating, purging and diuresis I fully agree with Dr. Laidlaw as to the superiority of the diuresis, believing that in the end much more harm is produced by the two other methods than good is done.

There are, unfortunately, cases in which we are obliged to resort to what is, after all, a species of mechanical treatment, for the relief of urgent symptoms due to the effusion. The kidney is the normal avenue for the expulsion of fluid from the body and also for the excretion of those irritating substances whose presence in the blood is one of the main causes of dropsical effusions. And it is the proper action of the kidney to which we must look for relief. Diuretics may at times be necessary to stimulate the function of the kidney epithelia and still more often tapping will be necessary to relieve the intense intra-abdominal pressure which by inhibiting the functional activity of the kidney prevents relief by that avenue. But if the patient is to receive any but the most transient benefit it must be through the influence of a drug homœopathically indicated, acting on and righting a perverted cell metabolism.

DR. MOFFAT: Dr. Laidlaw dropped one hint that I would like to see followed up. He said that homœopathy offers us the best hope for discrimination between the different remedies, diuretics and purgatives. Of course the pathological condition is part of the totality of the symptoms, whether the case is splenic or hepatic dropsy, etc.; but I wonder if it would not be possible to make a study of diuretics or anti-œdema remedies, taking from the primary effects of large doses of the drugs.

DR. LAIDLAW: I have only a few points to mention, Mr. Chairman. One is in relation to Dr. Moffat's remarks as to discriminating between diuretics symptomatically. I wish that could be done. Rademacher, from whom I have learned a great many things, was contemporary with Hahnemann. He was familiar with the Hahnemannian writings, and he denied that there was such a thing as symptomatic indication of remedies. The rule he gave was to try a remedy, and if it didn't work, try another. That is a very crude rule and rather experimental, but he claimed that in the nature of things that was as near as you could get to it. Not that he would not like to get better, but that to follow symptomatic indications was misleading. The only thing was to take a certain number of remedies and try them one after another. I would like something more exact than that, but as yet I do not know it.

The second point is in relation to Dr. Simonson's remark that cases of œdema developed in chronic nephritis while the urine remained abundant. I think those cases are rare. I have never seen a case where the urine remained over sixty ounces for three

days in succession where the œdema was not rapidly vanishing, and I think those cases must be very unusual. I say it not academically or theoretically but practically. One of the elements of the development of œdema is the decreased ability of the kidneys to excrete water; and I think in all cases of œdema where you can increase the urinary excretion you will get at least a temporary subsidence of the œdematous condition.

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# INFANTILE SCURVY.

GEO. H. JENKINS,
BINGHAMTON.

This disease has received but scant attention till very recent years. It is liable to be confused with other diseases, especially rheumatism; a correct diagnosis is essential to proper treatment. These are my reasons for writing a paper upon this topic.

My experience with this disease has been limited to two cases. Both had been treated by old-school physicians for rheumatism, and, I hardly need add, they continued to grow worse.

Case One.—Frederick H.; aged 10 months; only child; family history good; had never been sick till he developed this trouble some weeks previous to my first visit. Plump and flabby; bottle baby, the only food having been malted milk; slight rise in temperature; weak; profuse head sweat during sleep; constipated; he had the two upper incisor teeth; the gums were purple plum color and swollen so as to hide all but the points of the teeth; teeth, gums and whole mouth foul; hard swellings on the legs just above the ankle joints. There may have been other swellings, but at that time I was not well read concerning the disease and did not know where to look for others; if there were others they were not so prominent, for I had the child stripped and examined him very carefully. He seemed sore all over, cried hard when handled as though in severe pain, did not want to be touched, preferred to lie in his carriage. Very peevish, lay on the back with legs and thighs partly flexed; hair worn off the back of the head; cried out during sleep.

The diet was changed on the first visit to thin strained oatmeal gruel and raw milk, equal parts, with one-half to one teaspoonful Trommer's extract of malt added to each feed. Later, juice from rare steak was given in addition.

The bowels were relieved by glycerine enemata, and the child was taken out for an airing each day. The mouth was swabbed with diluted Listerine.

The remedies were, calcarea carb. $6^x$ trituration, which covered the general condition, and apis $12^x$ trituration for cerebral irritation from advancing teeth.

Improvement began at once and was continuous. The gums began to recede in a few days; indeed the change seemed remarkable; I had feared sloughing, they were in such bad condition. In two weeks the gums were healthy and the mouth sweet and clean. At that time I lanced the upper lateral incisors, which were well advanced.

The bowels soon began to act normally. In all I made five calls, the last one nineteen days after the first. I left him well.

Case Two.—Emma B., aged seven and one-half months; tenth child; no decided family taint; fairly well developed; at birth about an average child. As in the other case she had been treated for a month or more for rheumatism.

She lay on the back with the lower limbs partly flexed. Hair worn completely from the back of the head till it was as smooth as a billiard ball. Cried when touched or moved, and seemed sore all over. Very worrisome night and day, requiring constant care. She avoided both voluntarily and involuntary motion. For two weeks she did not move her arms; fever moderate; sweat, especially on the head; cried out in sleep; bowels variable, sometimes too loose.

There were hard swellings on the legs just above the ankles, and lesser ones above the knees, wrists and elbows. These swellings were deep in, as though on the bone, hard and very sensitive to pressure. The skin over them was normal, as it was also in the first case.

This case varied in one important particular from the other case. This child had cut no teeth and the mouth was in a healthy condition. An error in diagnosis was, therefore, more excusable. The child had been fed exclusively on a particular brand of condensed milk. I at once regulated the diet; the remedies were selected on the symptoms, phosphorus, bryonia, cuprum aceticum, podophyllum and calcarea carbonicum being used during the disease.

My professional attendance extended over a period of twenty-one days. Recovery was rapid. I judge from my reading that these cases were typical and of average severity.

ETIOLOGY.—The disease is most common during the last half of the first and first half of the second year. Faulty diet is the prime cause It never occurs in infants at the breast, but only in those fed on some form of prepared food, as malted, condensed or sterilized milk or some of the many baby foods with which the market is flooded; and as these foods have increased in number and become more popular with the laity the disease has increased in frequency. Unsanitary surroundings are never capable of producing it, though it is reasonable to suppose they may have an influence when the diet is at fault. Cases occur in the middle and upper walks of life when the babies have every care but also a faulty, though carefully selected, diet.

SYMPTOMS AND MORBID CHANGES.—Most of the symptoms have already been given in the two cases related. The onset of the disease is abrupt, after the cause has been operative for some time.

The patient is usually plump and apparently well nourished but not really so. He may have taken on fat, but his bones, muscles and

nerve centers have suffered. The first change noticed is in the complexion, which becomes pale and sallow, and the conjunctivæ, pearly white. The flesh is flabby; he becomes less active and cries when touched or handled.

If the child has stood or walked, he no longer attempts to do so. The thighs are kept flexed and the limbs droop, in a condition of pseudo-paralysis. The condition has been confounded with paralysis.

Swellings appear, which are greatest just above the ankle joints, but perhaps also above the knees and elbows. Swellings have been observed about the head and the scapulæ. These are due to hæmorrhages under the periosteum and are identical with those occurring in scurvy of adults, but of greater degree. There is no local heat or discoloration over the swellings, they shine and do not pit on pressure.

The powerlessness of the little sufferer is very striking. He lies on his back, does not move, or but little, screams when touched or even approached. He has an anxious expression and gives piercing screams at night.

In advanced cases striking changes are seen in the thorax. The sternum and costal cartilages appear as though thrust back in a mass, and occupy a plane posterior to the ribs. This is due to partial fracture of the anterior extremities of the ribs. The epiphyses of the long bones may be separated from the shafts. Sometimes in a few days from the onset of the disease, a sudden change takes place in one or both eyes, the eyeball being displaced downward and forward, and the lid ecchymosed. This is due to hæmorrhage into the orbit. Bruise-like spots may appear in severe cases, but not over the lesions of the bones.

If no teeth have been cut no change takes place in the gums. This is analogous to the condition of adults who develop scurvy after losing their teeth, they have no lesion of the gums.

(Since writing the above I have read in the Medical Review of Reviews the following: "In about one-half of the cases collected by the American Pædiatric Society, in which no teeth had been cut, the gums were involved." I was surprised at this statement, as it differed so from anything else I had read.)

If the teeth have been cut, unhealthy, hæmorrhagic granulations spring up about the teeth, sometimes nearly or completely covering them. The gums are spongy and bluish red or dark purple, sometimes ulcerating. The breath is peculiarly offensive.

In the respiratory system, if the changes in the bones are marked, there is shortness of breath; such a child may die of pulmonary complications.

In the circulatory system there is profound anæmia; but unlike any other anæmia, improvement is very rapid under proper treatment.

The bowels are usually constipated and there may be blood in the stools. There is not much fever and the temperature may be normal; but with successive lesions there is a slight rise, especially if the tension of the swelling is great.

MIXED CASES.—Scurvy is readily grafted upon rickets, and some physicians take the ground that every case of infantile scurvy is complicated by rickets, and call the combination "Barlow's Disease." While this may be of frequent occurrence, I do not believe that all cases of infantile scurvy are so complicated. Dr. Thomas Barlow, of London, England, has given the disease much study and has written about it in the medical press, and has a long article on it in the supplement to Keating's diseases of children. But he does not claim that rickets is always present.

After the sponginess of the gums has subsided, which occurs in a few days under proper treatment, and the effusions have absorbed, there may be evidences of rickets left, which will be slower to yield. But in most cases the recovery is rapid and complete, showing that there is no element of rickets.

Rickets does not have the great tenderness of the limbs, but in some cases there may be this tenderness, without perceptible swelling, which quickly subsides on an anti-scorbutic diet, showing an element of scurvy.

So, then, either disease may complicate the other; German writers have described infantile scurvy as acute rickets. The most marked points of distinction between scurvy and rickets are: Scurvy has the hæmorrhagic lesions of the gums and bones, the crying out by night, the great sensitiveness on being handled, and the pseudo-paralysis. In rickets the bones are distorted by pressure and the force of gravity; the long bones bent and twisted, the thorax is out of shape, the skull elongated antero-posteriorly, the fontanelle is large, the sutures are thickened, the forehead is high, square and may be prominent. The spine may be curved and the ribs beaded. The sensitiveness to touch, the crying out by night, the hæmorrhages and pseudo-paralysis are absent. It is a slower disease in its development and in its retrogression and always leaves permanent changes.

PROGNOSIS.—The disease is very amenable to treatment and a case properly treated shows improvement in a very few days. Recovery from all the lesions is usually complete. The patient may die of some digestive disturbance. If complicated by rickets, the manifestations of that disease will persist after the scurvy is cured.

TREATMENT.—In the light of the cause of the disease, the treatment is very apparent. The diet must be radically changed. Raw milk, sieved potato, fresh fruit juice, as that of orange, and the juice of rare steak will be all sufficient to effect a cure. But we have remedies at our command that hasten the cure. The calcareas, phosphorus and silicia are most often indicated.

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## DISCUSSION.

DR. DEARBORN: *Mr. Chairman*, these cases of scurvy in children are very interesting from several points of view. First, as a matter of diagnosis. They are often mistaken for other affections, particu-

larly by physicians who are not well up in the medical literature of the last four or five years wherein cases of this disease have been described. I have seen three or four cases of mistaken diagnosis because of the external lesions, and one of these cases had been treated for several months for supposed hereditary syphilis. This child had a sub-periosteal tumor which projected above the surface of the bones of the head, the size of an English walnut, and led the physician to assume that it was a gumma. A little investigation of course did entirely away with that mistaken diagnosis, because the distinctions are very clear. The only point left out in this admirable paper is a little lack of emphasis on the prevention of infantile scurvy. Of course the prevention can be inferred from the method of treatment; but if it is ever necessary to rear children on a sterilized diet, which I do not believe, that diet should always be accompanied by some fruit juice. Every infant, even a week or two weeks old, can take a little orange juice daily if it is necessary to give it sterilized milk, or to rear it on sterilized food, and a teaspoonful of orange juice would entirely prevent the development of these diseases in the cases I have seen. The rapidity of improvement has been more marked when the fresh fruit juice was used than when any other method of furnishing sterilized food was adopted; and of the two remedies in muscular sensitiveness, which seems to cause the greatest amount of suffering to children, bryonia or rhus, whichever is indicated, have given the most pronounced relief.

CHAIRMAN WARD: I remember very well indeed a case of my own, a child, in which I had tried very diligently to give relief, in a case almost like marasmus, with many of the symptoms of scurvy, and which after trying all other remedies, yielded very nicely by simply giving the juice of the grape several times daily.

Speaking of scurvy, there is one thing more that sometimes will help to produce scurvy, or what simulates it very closely, and that is the habit of some nurses or mothers of putting a pinch of salt into the milk. I have seen cases where that produced almost the typical symptoms of scurvy. Leave out the salt and the patient will get entirely well.

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# ALOPECIA AREATA.

WM. L. LOVE,
BROOKLYN.

Alopecia areata is a localized area of baldness which begins suddenly upon an otherwise apparently healthy scalp and produces smooth, white, shiny patches which are circular in shape, sharply defined, and of variable size. Not only are the scalp and beard attacked, but also the pubes and axillæ.

The disease usually appears first either at the top of the head or the parietal regions, although in two cases that I have treated, the margin of the hairy scalp at the back of the neck was first encroached upon, the patients noticing, quite incidentally, while combing the hair, a smooth, roundish bald spot about the size of a five-cent piece. In neither of these cases were there any premonitory or accompanying symptoms, nor was there anything in any way to account for the trouble.

The condition may remain stationary or it may advance rapidly, these isolated spots coalescing until the entire scalp is involved. I remember seeing such a case at the New York Skin and Cancer Hospital, the patient (a young lady of twenty-five) having lost every particle of hair on her head, so that it was as smooth as a billiard ball. The eye brows were also gone. In all other respects the health of the patient was excellent, and she could ascribe no cause for this affliction.

Alopecia areata has no connection with ordinary baldness; it may attack very young people or those with a good growth of hair. There is usually no itching nor other subjective sensation.

In regard to the etiology, several cases frequently occurring in one family indicate a hereditary tendency; many have considered it to be due to a vegetable parasite, but the predominant opinion is that it is due to a neurotic basis or a functional nerve trouble. Statistics show that it is more common in males than in females, although the four cases that I have treated have all been females. The diagnosis is easy; trichophytosis, or ring-worm of the scalp, being most liable to be confounded with it, but in this trouble the hairs break off instead of falling out and leave rough, uneven scales, while in alopecia areata the spots are smooth and well defined. The prognosis should be guarded, as some cases are, without apparent cause, very stubborn, even to the most careful treatment. As to the treatment, phosphates should be given in the diet and articles that make nerve food, as fish and fats.

The cause of the trouble should be learned if possible. I remember one lady that I treated, I found had suffered for some time with menorrhagia, there being a frequent dark, clotted discharge. Crocus $\theta$ was given internally with good effect. Another—a young lady—suffered with anæmia. Dialyzed iron in doses of one to two teaspoonfuls with meals, was given her. During the last two winters I attended frequently the Wednesday afternoon clinics held by Prof. Bulkley at the Skin and Cancer Hospital, at Nineteenth Street and Second Avenue, New York. I saw there several of these cases of alopecia areata and adopted his treatment for all my four cases. It consists in stimulation by pure carbolic acid, which is rubbed over the affected surface and among the hairs surrounding the patch, until the surface becomes white. This may cause a good deal of burning and irritation at first, but it soon wears off. In a week or so exfoliation of the epidermis takes place, then the carbolic acid may be re-applied. The method of application is to wind a little

cotton tightly around a tooth-pick or probe and then dip it in the pure acid and rub the scalp gently over the affected area. It is singular that the scalp is not affected by the usual caustic effect of carbolic acid. Where a large surface is involved sulphur ointment well rubbed in is useful, and stimulating lotions, as quinine and zinc or cantharides and capsicum are applicable.

As Bulkeley says: "Internal treatment has very little immediate effect, but it is of great importance in reference to an ultimate cure." The four cases that I referred to all recovered in from two to five months, although one lady, when she came to me, was wearing a wig to conceal three bald spots each the size of a half dollar. At first, the new hair comes in very white and fuzzy, but it finally becomes thick and brittle. The return to the normal is, of course, hastened by shaving the spots frequently after a little hair has grown.

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## DISCUSSION.

DR. CHARLES A. GWYNN: *Mr. Chairman*, Alopecia areata fortunately occurs very rarely in private practice, but it is very common in the dispensary and in the management of children's hospitals where the children are poorly nourished and come from very uncertain origin. Twelve years ago, when I had charge of the Five Points House of Industry, we had about twenty-five cases at one time. I started out on the supposition that they were possibly of neurotic origin. Now, obviously, there could not be twenty-five cases of neurotic origin very well in a house of 350 children, all having that one particular lesion. It seemed to demonstrate the fact that the cases as there existing must be of parasitic origin. Some of them had withstood all sorts of treatment, and the first thing that I attempted to do was to carry a parasiticide as deeply as possible into the skin. That I attempted to do with applications of heat, so as to open the pores of the skin as rapidly as possible. Next, the application of bi-chloride of mercury in ether. Theoretically that was beautiful, and practically it was nothing. Carbolic acid had not as yet come into vogue. Alopecia can, of course, be mistaken for two other diseases. One is the alopecia that comes ordinarily with most cases of syphilis, and the other, as the doctor has stated, ring-worm. The diagnosis is quite easy. With ring-worm, of course, we all have in our minds the typical appearance of a ring-worm. In those cases we used to succeed very nicely with white precipitate ointment. The alopecia coming from syphilis, in my opinion, does not require a great deal of local treatment. If it does get any local treatment, a lotion or ointment which contains both cantharides and oil of bitter aloes, does very well. But, of course, with syphilis the absolutely important part of the treatment is the administration of iodide of potash, and the alopecia of syphilis disappears quite readily, usually when iodide of potash is administered continuously. The

true alopecia, alopecia areata—I am quite struck with the doctor's report that all his cases have recovered; because in a true case of alopecia apparently the hair bulbs are entirely destroyed, and in some cases it would seem to me as though it were sometimes impossible to get the very excellent results that our friend, the doctor, got. In that affection we got excellent results from the repeated application of Spanish fly blister, the ordinary canthos. The blister was applied over the round spot that was devoid of hair, and the blister paste was kept on until a very decided redness of the scalp was caused. That is more difficult to produce on the scalp and on top of an alopecia than one would think possible, but if the cantharides blister is repeated and repeated, after a little time, in the bulk of cases the hair will make its appearance; and I am very much pleased to learn that carbolic acid has, in the doctor's hands, proved so successful, in what I think the ordinary experience of the profession would lead one to believe is an extremely obstreperous disease.

DR. PARTRIDGE: I have not had a large experience in the treatment of alopecia areata, although I have had three or four cases. I well remember the first case that came to me, that of a young lady with a very, very heavy head of hair. She was very anxious in regard to the result. It appeared that she would lose her hair, which seemed to be her chief pride. There were three or four spots of considerable size. At that time I was not particularly acquainted with the treatment of the case, but blundered upon a treatment that did me great service. I made an application of the galvanic current, at times applying a plain sponge electrode, and at other times the electric brush, which soon brought a redness to the surface and improved the nutrition of the skin so much as to increase the growth of the hair. Since that time I have treated all such cases in like manner, and in all the cases treated I have had the happy result of a complete recovery.

DR. H. M. DEARBORN: *Mr. Chairman*, The pathology of alopecia areata is a matter of controversy, and many eminent authorities believe that it is entirely a parasitic disease, that it is related to ring-worm. One observer who has made a thorough study of cutaneous fungi and a most extensive investigation regarding ring-worm and its varieties, believes that alopecia areata is probably of the same nature, that is, a disease due to a vegetable fungus. But as a matter of clinical observation there appear to be two varieties of alopecia areata, one of them more often occurring in children, probably parasitic, and in many of these cases we find broken hairs at the border of the patch, indicating that something has interfered with the nutrition of the hair. Another class of cases more common in adults appears to have some features of a neurosis, and these do not respond to anti-parasitic treatment. I am almost persuaded that local treatment alone is of little value. In a large experience in clinical work among all ages, children and adults, I have obtained nearly as good results without as with local treatment of this affection. The indicated remedy has proved nearly as beneficial and nearly as rapid in its action as the

combined local and internal treatment. Whether these cases were parasitic or neurotic it was impossible to determine except by the one feature of the broken hairs. In private practice, where we are often compelled to use local treatment, the recovery is not more rapid. If we find evidence that the disease is parasitic, it is likely in the hair follicles, and that is the important point to remember as to local measures, and that if you wish to reach the disease from the surface, you must choose some anti-parasitic application which will penetrate into the follicles. The destruction of the surface with carbolic acid is of doubtful value except as a preliminary treatment. If you apply carbolic acid, it, of course, produces necrosis of the superficial epithelium, effectually destroys any growth there may be in those epithelia, but it does not penetrate into the follicles. Rather, it prevents penetration, because it produces this superficial necrosis and possibly stops up or covers up the follicles. If the disease is parasitic I believe the most practical method of treatment is the use of something first which will remove the loosened epithelium, and I know of nothing better than friction with tr. of green soap. Afterward you can apply carbolic acid, extending it one-fourth inch beyond the hair line, and follow it later with some application which, after the dead tissue has been removed, penetrates into the hair follicles. There is no remedy that I know of which has so much effect upon the follicles of the skin as some form of mercury, simply because it can be forced mechanically into the follicles, probably becomes volatilized and produces its effects in those glands. The preparation which contains the least proportion of mercury to produce the desired effect is the best preparation, and that is ammoniate of mercury. A preparation of one per cent. or less thoroughly rubbed into the skin, using considerable pressure, will, I believe, have more effect than a very much stronger preparation of calomel or of the crude mercury. After all, many cases do not respond even to this treatment, and then the mechanical treatment to increase the nutrition of the hair comes into play. I have found in some cases which seemed to resist all other methods of treatment that electric or galvanic massage was effective. This can be done with about five or six milli-ampere meters, using the massage electrode, and very often will bring about a growth of hair when other agencies seem to fail. Patients, however, can do very much for themselves by making frequent manipulation of the scalp. That is, they can draw the scalp up between the fingers half a dozen or a dozen times a day, until a little color comes into the surface, showing a larger flow of blood, which tends to increase local nutrition.

One word as to the prognosis. In nearly all these cases the chief question in prognosis is the matter of time. Although you can nearly always promise recovery in alopecia areata, you must take sufficient time to carry out a systematic method of treatment As I stated in the beginning, I am not sure but that a well indicated remedy is just as effective alone as all the methods of external treatment combined. Good indicating symptoms, however, are not

often present. The remedies which I have found more often indicated are phosphorus, cal. phos., fluoric acid, vinca minor and sepia; but there are, I should say, eight or ten other remedies which may need to be differentiated in this disease. (Applause.)

DR. LOVE: I have nothing further to say except that I am interested to know about the use of electricity. I presume that the negative pole of the current, being the more stimulating, is applied directly to the part.

DR. MOFFAT: I would like to ask Dr. Love if he has not tried the high tension electricity for that.

DR. LOVE: I never heard it recommended until to-day. The results I have had with the application of the carbolic acid have been so satisfactory that I never used anything else; but in any obstinate case where the remedies I have given do not seem to work as well as I would wish, I am glad to learn that electricity has been used in that connection, because I see how useful it may be in stimulating the hair follicles.

DR. DEARBORN: The negative pole is invariably used.

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# REPORT

OF THE

## BUREAU OF PÆDIATRICS.

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"Ileo-colitis in Children," - - - - - - J. G. CHADWICK.
"The Child's Liver," - - - - - - H. E. MERRIAM.

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## ILEO-COLITIS IN CHILDREN.

J. G. CHADWICK,
BUFFALO.

Ileo-colitis is an inflammation of the mucous membrane of the ileum and colon. Characterized by pain, tenesmus, and mucous, bloody stools. Up to a few years ago the word dysentery was used almost entirely in all grave lesions of the intestines. The term ileo-colitis is now accepted to be the more specific and popular and includes under its head all the marked and grave lesions of the intestines.

There are three varieties of ileo-colitis: first, the catarrhal; second, the diphtheritic; third, the amœbic. We shall only consider the

catarrhal variety, as that is the most common form met with. If I use the term dysentery in describing this form, it is simply for convenience, and expresses the most prominent symptoms resulting from these lesions in the ileum and colon.

Catarrhal dysentery may be acute or chronic, sporadic, endemic or epidemic. This disorder may occur at any age, from birth to puberty; but as an independent affection it is met with most frequently between the first and tenth year. Race does not seem to bear any special influence; as it does not exist among any one nationality in the community. Sex exerts no influence, as it occurs as frequently in boys as girls. While the disease may be more frequent among the poorer classes, its severity is not lessened by high social standing; for it can be found under all social conditions, from the highest to the lowest. It occurs more frequently in the city than in the country; but when thus occurring there is as much severity in the latter cases as in the former. The fresh, pure air, and the healthful surroundings in the country exert a beneficial influence; where, on the other hand, neglect, poverty, ill-ventilated and uncleanly apartments, and insufficient and foul clothing act as strong predisposing causes, by their depressing action upon the general resisting powers of the child. Hence it is more apt to be met with in crowded tenement houses and unsanitary dwellings.

There is a popular belief that ileo-colitis is the direct result of teething. My experience has not borne that out; for I have never found the evolution nor eruption of the teeth responsible for its causation. Improper feeding seems to be the most potent etiological factor in these cases. In order to establish a direct relationship between dentition and dysentery you must exclude every other etiological factor. The most frequent as well as the most powerful causative factor is improper feeding. The food may be faulty in quality or quantity, or in both. Even pure food could act deleteriously if given in too large quantities; and impure food in any amount would prove injurious. It occurs most often in babies who are artificially fed; although the breast-fed baby is not exempt. The artificially fed baby is not only subject to the perils consequent upon ill-prepared cow's milk, but also to the dangers of the wholesale use of indigestible "table food." It is a frequent sight to see a baby crying in its crib or carriage with a partly-filled bottle of decomposed cow's milk, or, which is much worse, a concoction of some patent "infant food" lying beside him, with his lips against a fly-infected nipple, with which he takes comfort day and night.

Sometimes the changing of drinking water will irritate the intestinal canal, regardless of whether or not the water contains harmful germs. Weaning has been thought by some to be an etiological factor; but coincident with it is the introduction of artificial food a recognized cause. Sudden changes of temperature, particularly when exposed to sudden and rapid falls, or exposure to draughts of air may, by chilling the body, cause dysentery.

Bacteria may play an important part in the production of the disease; but as yet the specific germ for this, the catarrhal variety, has not yet been found. Finally, I think we are forced from the variations in the anatomical lesions of this disorder to draw the conclusion that not one single etiological factor will cause them.

The lesions of catarrhal dysentery are important from a pathological point of view; and these lesions are usually confined to the lower part of the colon and rectum. There is more or less intense hyperæmia of the mucous membrane; and there may be even slight hæmorrhages into the mucosa and submucosa. The congested mucous membrane may vary in color from bright red to dark purple; and the membrane is usually covered with tough, tenacious mucus. The large intestine is empty while the small one is distended with gas and contains a thin, greenish liquid. The mucous membrane is commonly swollen and grayish in color. The solitary lymph-follicles along the colon are swollen, sometimes to the size of a small bean, and surrounded by a hyperæmic area. Between these inflamed areas the mucous membrane may be found normal in appearance. Ulceration may take place; the ulcers at first are round and superficial, but soon enlarge, two or more coalescing and forming ulcers from one-half to one inch in diameter, often exposing the muscular coat of the intestine. Ulceration in different stages of development may often be found in the same individual. Cicatrization begins upon the floor of the ulcer, its edges being drawn toward the base. Perforation and peritonitis, which are seldom seen in children, may result from the ulcerative process extending through the intestinal coats. The liver, which is usually congested, may be the seat of multiple abscesses. The mesenteric glands are enlarged and softened and are dark blue in color.

The symptoms of all the forms of inflammatory ileo-colitis vary much, but in a general way they may be easily recognized by a group of symptoms, which differ from those of the non-inflammatory diarrhœas, spoken of as fermentative diarrhœa and cholera infantum. But as a rule the symptoms of the different varieties of ileo-colitis are very unreliable, when we are differentiating the disorders. The onset of the disease is usually very sudden, preceded by fermentative diarrhœa, and without any prodromal symptoms. The temperature is usually elevated two or three degrees; depending, of course, upon the intensity of the inflammation. The pulse is quickened, weak and oft-times compressible; the strength becomes likewise diminished and the child quickly loses in weight and strength. Some authorities say there is seldom abdominal pain or tenderness on pressure; but in the cases I have had the tenderness and pain have been present. There is frequent desire to go to stool, with much tenesmus, especially so when the lesions are in the rectum. The stools, which first contain fecal matter, soon become smaller and consist of mucus, with the addition of pus, blood and sometimes shreds of membrane. The odor may be offensive, but when the discharges are mostly mucus there is very little odor present.

The stools vary in frequency; may be from five to ten to even forty or fifty in twenty-four hours. The blood found in the stools is usually from congestion of the blood vessels, and from straining, more than from any ulceration; therefore we cannot determine entirely because there is blood in the stools, that we have ulceration present. At first the abdomen is quite soft and not tender, but later in the course of the disease it becomes distended with flatus, and quite sensitive to pressure, especially along the course of the colon. Vomiting may occur at times. In severe cases the child may be very restless, and there may even be delirium and convulsions. The urine is usually much lessened in quantity, high-colored and contains a small amount of albumin; especially if the temperature is at all high. The pulse becomes rapid, thready and intermittent, and syncope threatening. The respirations become sighing and the voice inaudible. The eyelids are partially closed, and the pupils widely dilated.

The diagnosis should be easily made, for in the early stages the disorder it would simulate most would be acute intestinal catarrh; but when we get the characteristic stools of ileo-colitis all doubt will disappear.

In ileo-colitis the stools contain much mucus, blood, pus, and perhaps small masses of fæcal matter, and are odorless; usually having the odor that one gets from "fresh meat." Tenesmus is present in all cases; the patient will be found bathed in a cold, clammy sweat; is exhausted and probably faints.

In acute intestinal catarrh the evacuations are usually much larger, and when blood is present it is usually in streaks and not found mixed with mucus; the pain is much more intense, and often paroxysmal, and tenesmus is seldom present.

Sporadic cases can be differentiated from the epidemic ones by the prevalence of the latter in the community.

The prognosis in the catarrhal form of ileo-colitis is usually favorable. The ordinary duration of the disease is from eight to ten days, but it may prove fatal in from twelve to seventy-two days.

If ulceration be present, then the prognosis is unfavorable. When the discharges begin to diminish and fæcal matter again appears in the stools, together with a lessening of the nervous symptoms, then the prognosis can be considered good; but if the symptoms increase in severity and the face looks pinched and intractable, vomiting and nervous symptoms predominate, then it is that our prognosis should be carefully guarded.

The preventive treatment of these affections consists in attention to all details of infant hygiene and the use of milk free from bacterial contamination. Inasmuch as one can never be certain, especially during the hot months, that cow's milk is pure and non-toxic, it is well to employ milk that has been pasteurized.

Some of my patients I have advised not to take milk that is sold in bulk from the milk wagon, nor even from those who place the milk when they get it, into bottles; but I have had them use milk from a dairy, where the milk has been pasteurized before coming into

the city; then we are sure that the milk is as good as can be had, and I have found that children who are given this milk thrive and grow fat, and rarely have any intestinal irritation. When we find that the majority of these cases are produced from contaminated milk, and that if continued only adds to the fermentative process, then the first essential in the treatment is to discontinue all milk preparations.

The bowels should be thoroughly irrigated, preferably by use of fountain syringe with a soft, rubber catheter attached; the latter passed into the bowel almost in its entirety, then using water that has been boiled, with or without castile soap; or we can use a weak salt solution.

It is wise to continue these irrigations until the return flow of water is perfectly clear. Some object to free irrigation, but I have never seen any harm follow its use; surely it cannot cause as much suffering as do the symptoms the irrigation is supposed to alleviate. I have several times relieved the extreme pain and straining by irrigation. In a child of eight or ten years it is necessary to inject as much as two pints directly after the stool; but with an infant much less than this must be employed. It is well always to inject the fluid very slowly so the inflamed coats of the intestine can accommodate themselves to the increased tension. The frequency of the irrigations must depend entirely on the number of stools, the strength and age of the patient. If the little one can stand it an irrigation after every stool would, no doubt, be beneficial. Some authors advise the injection of cold water, and even ice water; but I should dislike to try the experiment on any of my patients, for fear of shock, and the latter proving fatal.

If antiseptics of any kind are needed, then bi-chloride of mercury 1 to 10,000 is the preferable solution; but as the cleansing of the bowel is the object sought for by irrigation, then the nearer we come to warm, sterilized water the better. In regard to the diet, it must consist of liquid food from the very beginning. The nursing infant should continue to take the breast unless some condition of the mother, or her milk, is contra-indicated. In all others pasteurized milk, beef tea, broth, beef juice, etc., may be given and these in alternation, so that the little one will not grow tired of any one article in the diet. In regard to therapeutics, much can be done by our homœopathic remedies.

*Aconite*—If given early, is often able to cut short the trouble, without any other remedy. If the case sets in with violent fever, aconite will many times cure the disease in from two to three days. There is fever, anxiety and restlessness. Pulse is full and hard. The stools are bloody, slimy, mucous, scant and frequent, with tenesmus.

*Aloes.* There is violent tenesmus. The stool consists of lumps of mucus, or bloody mucus. Sense of weakness in the rectum as if the stool would escape involuntarily. Weakness and faintness after stool.

*Arsenicum.* Given in the late stage, when there is extreme prostra-

tion and restlessness. Violent, burning thirst, drinks little and often. Rapid and scarcely perceptible pulse. The stools are dark, watery, frequent and offensive.

*Baptisia* is indicated as soon as the disease shows a typhoid tendency.

*Belladonna.* Flushed face, dilated pupils, throbbing of the carotids. Head hot, hands and feet cold. The child is stupid, drowsy, starting, twitching of the muscles during sleep. The abdomen is very sensitive to touch. The passages are bloody and frequent. Dr. Bell says that this is often the only remedy required for severe cases of infantile dysentery.

*Cantharis.* Anxious, restless. Violent pains in the abdomen. Burning in the abdomen. Stools white or pale, reddish mucus, like scrapings of the intestines, bloody mucus. Tenesmus. Frequent, ineffectual desire to urinate. Prevention of the urine.

*Mercurius Carr.*—In this remedy we have an exact similimum to all the essential features of an ordinary attack of dysentery. Cold face and hands, with small, feeble pulse. Distension and soreness of the pit of the stomach. Continual urging to stool, with a never-get-done feeling; must strain. Faint, sickish, colicky pain in the abdomen, ameliorated by the stool, and prolonged tenesmus after the stool. Stools bloody, slimy, containing shreds of mucous membrane; they are scanty and frequent, with continued urging; faintness and weakness.

Other remedies that could be thought of are, nux vomica, Rhus tox., sulphur, kali bich., ipecac, colocynth and capsicum.

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## DISCUSSION.

DR. SIMONSON: *Gentlemen,* there is one word about these diarrhœal diseases in children that the doctor did not mention, that I think might be emphasized, and that is the question of diagnosis. There is no doubt in my mind at all that many of these cases of so-called protracted diarrhœal disease in children, and even in fairly young children, in infants, are cases of typhoid fever, and that the diagnosis of that condition is necessary both for the sake of the patient and for the sake of the family, those surrounding the patient, to prevent infection and to ensure the proper treatment of the case, and also to prevent disappointment with a slow recovery. It has only been in the last few years that typhoid fever has been recognized or admitted in infancy, and, in fact, some of our best known authors on pædiatrics state most positively that they have never seen in their personal experience any typhoid fever in a patient under three years of age, and that there are very few even in literature. Now, it has been my good or bad fortune within the last three years to see four cases of undoubted typhoid fever in children under two years old, and two of those were in children under one year old. The diagnosis

was confirmed by bacteriological examination, by the strong presence of the widal reaction in ten or fifteen minutes and by the persistence of the diazo reaction in the urine, and the diagnosis was also upheld by a prominent consulting authority. Now, I believe, as stated before, that typhoid fever is very much more frequent in infancy than we suspect. It almost always runs a benign course, and in the majority of cases the diagnosis is one of sub-acute inflammatory disease of the bowels, very frequently attracting the attention to the frequency and character of the discharges and disregarding the constitutional condition, disregarding the hygienic treatment of the patient and especially disregarding the matter of diet, doing a great deal of harm to the patient, prolonging the attack, and beside, putting those surrounding the child in a great deal of danger on account of the disregard of all precautionary measures to prevent the spread of the disease in the family.

Now, one other point. I would like to mention two drugs that I have found in true cases of ileo-colitis to be very effective, and which I do not think are used very much in children. One of them is pulsatilla. I think that pulsatilla is, notwithstanding the fact that in our materia medica there is no stress laid on tenesmus,—I think that pulsatilla is very frequently indicated. The large quantity of mucus in the stools, and especially the changeability of the stools, being at one time yellow, the next time green and the next time brown, in my mind is a very strong indication for the drug, and when used it almost always leads to very rapid good results. The other remedy is magnesium carb. I believe that very frequently mercury and calcium are given in alternation, one for the tenesmus and the other for the abdomen, when magnesium carb. alone would have done all the work.

DR. LAIDLAW: One thing I have learned by bitter experience in the treatment of ileo-colitis in children is that if I do not get a response in two days by remedy there is something the matter with the food, and I have learned practically to begin with the ideal food and follow it with remedies, with much better success than in relying exclusively on remedies and picking the ideal food afterward. You cannot pick an ideal food for a child before you try it. It may be sterilized milk, it may be malted milk, it may be desiccated; it may be beef juice. Malt acted in some cases as a purgative; used to give a dose of it every morning. In five cases after that it had no effect. Milk would move their bowels. So you have to try around with foods and get it right, and that seems to be the most essential point in the treatment of these cases of ileo-colitis, the remedies becoming of secondary importance.

CHAIRMAN MERRIAM: I have had the greatest success in the treatment of these cases, in regard to diet, from cutting them off from all food entirely except barley water. It is pretty hard for the parents to control themselves and "starve the child", as they say, but I have kept them on barley water for two or three days, and then go on with the milk or cream diluted, and egg and water, gradually getting

back to the normal food, something which by experiment will be found to agree.

DR. CHADWICK: I realized, Mr. Chairman, the close similarity between typhoid fever and the true case of ileo-colitis in the beginning, but in the cases I have had, there has been a quick response from the indicated remedies, and the cases have not lasted more than five to eight days, the temperature gradually coming down each day. I know the cases I had were no doubt ileo-colitis.

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# THE CHILD'S LIVER.

H. E. MERRIAM, M. D.,
OWEGO.

The liver of the infant is the same as that of the adult. It is subject to the same changes, both organic and functional, only these changes are not as frequent. The symptoms are the same, but they are not as easily obtained. There is one difference, however, and it is marked. It is the difference in size.

Every normal, newly-born child is, by weight, one-eighteenth liver. Comparing this with the normal adult, who is one-thirty-sixth liver, it will be seen that the infant's liver is relatively twice as large as that of the adult.

In examining the abdomen of an infant, the examiner, if he does not bear the above facts in mind, may say that the child has an enlarged liver. Such a diagnosis will naturally bring from the parents the question, "What is the cause?" Unless there is some real enlargement he will have to tax his imagination to satisfy the parents and himself.

This proportion between the weight of the liver and that of the body, in favor of the liver, constantly decreases, but during the whole period of infancy the liver is large.

On account of its large size it is easily palpated below the border of the ribs. The configuration of the ribs in the infant makes it easier to palpate the edge of the organ than in the adult. The size is variable even within the limits of health. The lower border will sometimes be found on a level with the crest of the ileum. It may extend to the left as far as the cartilages of the left lower ribs. In the median line the border is half way between the ensiform cartilage and the umbilicus.

Displacements will give the appearance of enlargement. The distortion of the chest in rickets will force the liver down into the abdomen. An accumulation of fluid in the pleural cavity will cause a displacement by pressure above. A condition of extreme weakness and general relaxation will allow the liver to fall, due to lack

of support. Where such displacements are suspected the upper border should be located by percussion. Normally the upper border in the nipple line is found in the fifth intercostal space, in the axillary line in the seventh space and posteriorly in the ninth space. Occasionally this line of dullness will be found higher up. The cause may be abdominal tumors or ascites.

As the liver of the infant is not often diseased, it is all the more important to be able to correctly diagnose such diseases; to be able to distinguish between normal and abnormal sizes.

That is my reason for writing this short paper and calling attention to the subject. When you examine a child's abdomen and find, as you may think, an enlargement of the liver, be sure, before you talk too much, that it is no more than he is entitled to.

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# REPORT

OF THE

## BUREAU OF LARYNGOLOGY AND RHINOLOGY.

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"Etiology, Symptomatology and Diagnosis of Tuberculosis of Larynx,"
J. H. HALLOCK.

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## ETIOLOGY, SYMPTOMATOLOGY AND DIAGNOSIS OF TUBERCULOSIS OF LARYNX.

J. HENRY HALLOCK, M. D.,
SARANAC LAKE.

I will comply with the request for a paper though I have nothing new to say upon this thread-bare subject. In looking over my case book of several hundred cases I am surprised at the comparatively few who have had any localized tubercular disease of the upper air tract, excepting the larynx.

Nine-tenths of all tubercular patients who have sufficient pulmonary lesion to be recognized will have an aggravated catarrhal condition of the nasal, pharyngeal and laryngeal mucous membrane, and as the disease advances this usually becomes more annoying, especially the pharyngeal and laryngeal irritation and in many instances this requires treatment to secure any degree of comfort to the patient. But this, no matter how aggravated, is not tuberculosis, it is only a congestion brought about by interference with the circula-

tion plus the irritation from the poisonous discharges which come from below.

During my five years' experience with throat and lung work in the Adirondack Mountains I do not recall a single case of tuberculosis of any portion of the nose or mouth and only one of the tonsil and two of the epiglottis. Bosworth, in an immense hospital experience, reports five.

About ten per cent. of all my cases have laryngeal tuberculosis. In a small percentage of cases this is the first recognizable symptom, though I doubt if it is ever the primary lesion. But in most cases it follows or is found with a recognizable lung disease.

It is known by all that consumption is not an inherited disease. But it is equally well known that the existence of a special diathesis is necessary, otherwise the disease will not readily be contracted. But this condition, called a tuberculous diathesis, is inherited and such people easily fall victims to the disease.

The direct cause of a tuberculous process in the larynx is lodgment or colonization of tubercle bacilli, and in a great majority of cases this follows a similar process in the lungs.

Laryngeal tuberculosis occurs most frequently in adult life, the majority of my cases occurring in patients between thirty and forty years of age.

Its first manifestation in the larynx is usually a circumscribed deposit in one side of the organ. Most frequently the primary invasion is in the membrane covering the arytenoid cartilage but it may develop in any portion. From this first deposit it extends laterally until the entire larynx may become affected. Or extension may take place by auto-inoculation.

The first symptom is usually a hoarseness or some interference with the voice due to some disturbance of the vocal cords and as the cords are invaded with the disease the voice becomes more and more impaired. If the arytenoids are much swollen there is usually difficulty in deglutition.

As the disease progresses the pain increases but it is usually not acute unless it extends to the epiglottis. Cough usually comes early in the disease. Sometimes, of course, due to lung involvement, yet always aggravated and made worse by the sticky discharges and irritability of the congested or ulcerated larynx. A feeling of swelling or fullness in the larynx is usually quite an early symptom, and what this annoyance can be even when acute pain is not present, one can have but a faint conception of unless he has been similarly afflicted.

It was one of my first symptoms and as it would not yield to remedies it made me suspicious and caused me to have my expectoration examined. The report of the microscopist made me less happy than ever, for tuberculosis was established beyond a doubt. Tubercle bacilli were found in large numbers and destruction of tissue was taking place, shown by the amount of elastic lung fibers present. But this irritation in my larynx was so much more annoying than

anything else, that I promised myself if I could get rid of it I would never scold about anything else that might develop.

Usually the subjective symptoms of laryngeal phthisis are so well marked, especially in those cases where there is well established pulmonary disease present, that a diagnosis can be made with certainty; and one, expert with laryngoscopic examinations, should be able to diagnose the disease early after the deposits have taken place.

The laryngoscopic examination will usually show the club or pear-shaped swelling of the arytenoids; sometimes we find one larger than the other but more frequently they are enlarged evenly and present the same appearance. The ventricular bands when diseased are usually on but one side. At an early stage of the disease the membrane presents a dull, yellowish, gray tinge and has an opaque appearance. But within a few weeks the membrane becomes studded with minute yellowish dots which mark the development of tubercular nodules.

As the disease progresses the tissue begins to break down and ulceration forms and there is destruction of tissue and the edges look ragged and worm-eaten. But the adjoining mucous membrane is so anæmic that it is frequently difficult to tell where the ulceration ends.

Tubercular laryngitis is always a grave disease, following, as it usually does, upon a lung involvement. Poisoning of the system sometimes takes place very rapidly after it develops and it is always a place to be watched to prevent rapid absorption of the tuberculous poison.

Do such cases get well? Yes, I have them in my own practice and the reports of brother physicians confirm the statement. But its treatment will be the subject of another paper.

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## DISCUSSION.

FRED D. LEWIS: In the discussion of this very able paper I find myself with very little to say. I would beg to take exception, however, to one statement that the doctor makes in regard to consumption being an inherited disease. True, the congenital constitutional condition of the system which renders the children of tubercular mothers more susceptible to the disease is the rule. But, although I cannot now quote my authority, I remember distinctly of reading the account of a number of autopsies made on prematurely born infants of consumptive mothers, in the lungs of one, at least, and, if my memory serves me rightly, of two or three, well developed tubercular infection was present. That, however, has nothing to do with this paper, as this deals with the upper air passages and not the lungs. As the doctor truly says, the disease in the larynx is usually an extension upward from a primary lung infection, but this is not always so.

One case whom I saw first on May 5th, 1900, presented a perfect

picture, in the laryngoscope, of tubercular laryngitis, but a thorough general physical examination by one of the leading physicians here revealed only a reduced percentage of hemoglobin from the normal. She improved greatly under indicated remedies, mostly calc. carb., calc. phos. and calc. iod. Toward fall I advised her to spend a month in the Adirondack Mountains. There she contracted typhoid fever which nearly proved fatal. She returned home to regain her strength, which came back to her as rapidly as could be expected. I believe, though, that her throat trouble was cured before she had the fever, as there has been no further trouble there and she has gained in weight and is perfectly well to-day. Most cases are seen so late, however, that their death-warrant may be read in the laryngeal mirror. As the author also says, the picture in the mirror is so characteristic that one who is at all accustomed to the use of the laryngoscope should have no trouble in making a diagnosis at a very early stage.

I do not wish to encroach on the subject of the paper to follow, on the treatment, but I cannot let the opportunity go by of mentioning the great help in the relief of pain, and in swallowing, that I have had from the use of orthoform. This powder blown into the larynx with a powder blower, two or three times daily, will insure comfort at least in the most advanced and desperate cases to the end.

DR. LANE: Dr. Lewis speaks of the use of orthoform as an anæsthetic in a case of that kind. I would state that in the use of orthoform after opening small abscesses, and continued use of it, I get sloughing, orthoform poisoning, and after stopping the orthoform for a while the surfaces healed considerably, but on resuming it the sloughing commenced again; so that it was undoubtedly orthoform poisoning, and I caution you to look out for that in any case of that kind.

DR. NICKELSON: I wish to say just a word about the Adirondack climate for consumption. If you have a patient that cannot afford to go to Colorado or California, if you will just send him to the Adirondacks he may receive as much benefit as he would from the longer journey. Those of you who have never been there have no idea what it is, the altitude and the heavy timbered climate of that region. Living in that section of the country I was in the habit of sending my patients there even twenty years ago. But do not send them for a month. Send them for six months, or even a year. Notwithstanding the severe winters, they will do better in the winter than in the summer. It is an absolute fact that a consumptive will do better in the cold, bleak winter there than in the summer time. Please bear that in mind.

DR. MOFFAT: One word about the Adirondacks, Mr. Chairman, from the personal experience of one of my patients. It is of vital importance that the patient be put in the care of a competent physician who is on the ground and who will carefully watch him. I am satisfied also that the patient being sent away for his health must be given some occupation. A patient of mine went insane with melancholia because he had nothing to do but think of himself and his symptoms.

CHAIRMAN HOYT: If there is no one else who wishes to speak I would like to say just one word about the diagnosis of tuberculosis of the larynx. The author stated in his paper, and Dr. Lewis said in his discussion, it is an easy thing,—but I think there are a great many cases where it is not an easy thing to diagnose tuberculosis of the larynx, if there is no area of infection in the lung which can be determined. We are left sometimes in doubt as to whether it is tuberculosis, syphilis or cancer. Where there is a doubt I think the safest thing to do at first is to put the patient on syphilitic treatment. If it doesn't clear up then, we have eliminated one factor. There are some cases of tuberculosis of the larynx where we do not get the anæmia of the mucous membrane about the fauces and pharynx which is a characteristic of tuberculosis; and then if we can eliminate syphilis we are brought up to face one of two very serious conditions. The climatic treatment and soothing treatment, like the emulsion of orthoform and menthol, seem to me to be the principal things that we can look forward to for that patient. The curetting and applications of lactic acid are rather barbarous, and are being abandoned to-day by a great many who spoke favorably of them before and used them very extensively. I have never seen any trouble from orthoform and have used it a great deal, and it does give an immense amount of comfort, to say the least, in laryngeal cases.

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# REPORT

OF THE

## BUREAU OF MATERIA MEDICA.

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"Study of a Heart Drug," - - - - - THOMAS C. DUNCAN.

Special Subject for Discussion: "How, as a society, shall we systematize the various efforts to improve our Materia Medica and how conduct future provings that we may meet the demands of modern science?"

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## STUDY OF A HEART DRUG.

T. C. DUNCAN, M. D., PH. D.,
CHICAGO.

All drugs taken by the healthy that affect the circulation affect the heart. How? is the problem. The student of drug action who thinks of some disease or diseases all the time will not get at the range and force of drug action.

1. We can, of course, study drug action in sections, and find out how it affects the head, mind, eye, throat, stomach, bowels, urinary tract, sexual organs, lungs, heart, extremities, skin, etc., but that is not sufficient.

2. The order it takes in making "the grand rounds," and the emphasis made upon any one or more organs can only be known by a study of its general action. That is the second way to study.

3. A third way is to note what emphasizes or what lessens the said general or special action—outside of the usual action of the body and its functions.

4. There is another way to study what a drug can do, and that is to try it on disease and note what *lesions* it will *remove*. Here we must know the action of the *vis medicatrix naturæ*, so as not to confuse it with the possible drug action. If the drug removes pathological lesions—so recognized by expert diagnosticians—then we may count these as possible drug effects. Our information gained as to what a drug will do in producing pathological lesions is gleaned (1st) from toxicology, cases of poisoning, or (2nd) from its clinical action and verifications. It is often dangerous to push a poison to that extent.

The whole of the profession have for many years been verifying the action of our many drugs in all sorts of diseases, so we have come to classify them quite accurately. Every new drug stands among the unclassified, and the profession asks the prover, naturally, in what group does it belong. Provings are piecemeal studies. Often it takes years to build up a pathogenesis so that the drug can be clearly labeled.

We get at the rank of the drug in two ways: First, by the group to which it seems related, and second, by its prominent or peculiar symptoms, verified by clinical experience.

We are all interested in drug classification, and there is a mass of clinical confirmations that should be given to the profession in such a way as to increase the number of sharpshooters in our ranks. The object of drug study, like practice at the "rifle range," is to help to make better therapeutic marksmen.

From my study of Hahnemann's Lesser Writings, etc., and from talks with Hering, I am satisfied that much of the "natural history of drug action" is lost to us of to-day. When Hering told Prof. J. C. Morgan, when proving gelsemium, that the lasting tendency to diarrhœa on hearing bad news, as of the fall of Sumter in' 61, etc., would prove a characteristic sympton. of that drug, he showed a knowledge of drug action (and of therapeutics according to similia) that few of us possess.

"All that other men can do,
Why, with patience, may not you?"

Now let us see how he got at it. The effect of a drug may be either (1) toxic, and (2nd) as we say "physiological", or in other words, producing structural or functional change.

1. The big dose is toxic, producing structural change—which means death in many cases.

2. A smaller dose produces a slighter toxic action, and a longer reaction, i. e., simply a physiological disturbance.

3. A still smaller dose may only give a slight disturbance of the organs, and in some subjects none at all.

Hahnemann divided drug action into primary and secondary, or action and reaction. He concluded that most drugs had these two actions (1796). That being true, if there is a primary action there must be a secondary action, and vice versa. If a drug produces diarrhœa in a primary action, it must have also a constipation. If it causes a slow heart we know it must also have a rapid heart. Prof. Evans calls these the continuous action.

As in disease we know that the characteristic symptoms are not usually the first or prodromal symptoms, but it is the later symptoms that determine the disease. A tumultuous heart with præcordial friction sound is, we know, subsequent to the chill, fever and præcordial pain and anguish of pericarditis. Now if we recognize the fact that the long lasting symptoms are the characteristic ones, both of the action and its severity, we get a little clue to Hering's ability to read drug action.

Hahnemann laid emphasis on these later symptoms in drug application, as we do according to similia.

I once asked old Dr. Lippe how he studied a new remedy. He said: "I read the proving over and over carefully, until something peculiar is noticed." Now Lippe's ability to notice peculiar things in a drug effect equaled that of a naturalist who knows the characteristics of a specimen. Here is our lack to-day. We need to learn to recognize the characteristics or symptoms or effects of drugs. He also was able to trace or know the course of action of the drugs, as pointed out by Prof. Woodward. Then he further said: "I give the new drug as often as I can, and note the symptoms removed, and the new ones produced. Then I finally know what drugs it is similar to, and also what it will do." Here you see three or four stages of study. Where are there any such steps pointed out in our books for drug study? Let us recount them.

1. The characteristic or peculiar effects or symptoms are to be noted. These are the naturalist's guide.

2. The order of effects is to be noted.

3. The emphasis must also be noted.

4. The relations, group or analogous drugs are to be noted for classification. So much for pathogenic study.

Hering emphasizes what Hahnemann pointed out, that the later symptoms are the therapeutic characteristic guides.

Now, to study out a heart drug, we must first be sure of our knowledge of physiology. Increased blood pressure from cardiac force or activity will disturb many parts of the body, viz., brain, respiration, kidneys, bowels, spine, etc. So we may have marked disturbance of the circulation and of other organs by a drug, and yet it not be essentially a cardiac drug. The bad news, while proving gelsemium, causing a diarrhœa, tells somewhat of its nervous character. It is also the case of a fever drug with a relief

through the skin increased by perspiration and by sleep. It is a Southern drug where the chief diseases are below the belt. It is related to coffee and cinchona. The first is a nervous drug and the second a nutritional one with a fever label. Here again it compares with aconite and belladonna. It has a more local whirlwind than aconite, and not so emphatic a one as belladonna. The fever of gelsemium is æsthenic, languid, stupid.

Now fever and rapid heart are inseparable. The stupor comes on to relieve the strong cardiac action, but there is a reaction where there is more nervousness, e. g., "Nervous chill, yet skin is warm; wants to be held that she may not shake so" in heart disease. While we also read of a "fear that unless constantly on the move, her heart will stop beating." Heinigke gives: "Acceleration of the cardiac action with a full and frequent pulse." Also "Retarded and weak cardiac contractions with a small and thready pulse; fluttering motion of the heart, irregular cardiac motion with intermitting pulse returning for from eight to ten days. Fibril motion with chills and heat." Here we see the so-called dual action, really a continuous action of this drug. The heart that needs bodily action to keep going is met in long lasting nervous cases. The heart muscles are weak, and need the capillary circulation increased by muscular motion. The first effect is upon the sensation, then through all the stages to muscular exhaustion, via fever. This explains also the bowel and vesical weakness when the nervous grip is weak. These are the cardiac symptoms that have been met in practice and cured by gelsemium.

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## SPECIAL SUBJECT FOR DISCUSSION.

"How, as a Society, shall we Systematize the Various Efforts to Improve our Materia Medica and how Conduct Future Provings, that we may meet the Demands of Modern Science."

DR. MOFFAT: The plan of re-proving proposed by Dr. Bellows, of the Am. H. O. O. & L. Soc., a couple of years ago and approved by us last year is more scientific and more practical than anything else I have been able to learn of. Every prover is to be subjected before, during and after the proving, to repeated examinations by specialists and to be quizzed on each symptom by his supervising physician. What is new in this proposed re-proving is the critical effort to ascertain the objective and the pathological condition with the aid of the most modern scientific means of analysis and diagnosis at the hands of specialists in conjunction with general physicians who are especially interested in materia medica.

DR. SCHENCK: Dr. Moffat has practically outlined the method used by the Bureau of Materia Medica in Brooklyn, but perhaps it might be well to go more into detail. This Society, at its last meeting, donated money to carry on provings under this plan of Dr. Bellows. In Brooklyn, under the direction of Dr. Bellows, we have

formed a large committee on proving. Dr. Moffat is the chairman and he has one or two assistants to help him, and we have beside that specialists who take care of the eye, the ear, nose and throat symptoms and the skin, a bacteriologist and analyst; and we take care to have all the secretions of the provers examined before the proving begins. We have already secured money from our County Society, $100, to pay our provers. The only expense connected with this thing, of course, is the payment of provers. It is impossible to have people give up their whole time, I think, to this work without pay, and we propose to get young men and young women who have just begun practice, or students who are at liberty to undertake the proving and carry it out in as thorough and practical a manner as possible. We have secured four provers, and pay them $4.00 a week for the work. In that way we expect to spend at least sixteen weeks in the proving of each drug, and going over them carefully. These provers are supposed to submit their records each twenty-four hours to the director or his assistant, and they are referred to such specialists as may be necessary for confirmation by objective examination and subjective symptoms that have been developed. It seems to me a practical plan at this time to put our materia medica upon a scientific basis upon which we can absolutely rely, better than any other that has been proposed so far. These proving boards, under Dr. Bellows, have been organized in New York, Boston, Philadelphia, Brooklyn, Buffalo, Cincinnati, Cleveland, Detroit, Chicago, Baltimore, Washington and St. Louis. Each one of those cities has organized a complete board just as we have in Brooklyn, and from the preliminary work done during the summer, Dr. Bellows proposes now, next month, to begin the active work of proving, and I should hope that before the next meeting of this Society something at least will be known about the practicability of the work of this committee and what success it has had in developing the proving of some remedies.

CHAIRMAN CRUMP: If we look back over the past few decades of the homœopathic school we see a marked increase from the numerical point of view, but with this constant increase of strength numerically there seems to be a lagging of energy and work along the line of drug proving, so that as we look over the literature of the past few decades we find that very little has been done, while in the times of Hering, Hahnemann and those older men, this grand materia medica, which is so helpful to us, has been built up. There is, however, now to be noted in some journals and some conversations with the profession a desire on the part of a great many men in different parts of the country to again stimulate into activity the proving of drugs. In New York we also have noted of late that there is a man of great wealth who has given a good deal of money toward the establishment of a school of medical research. That man, who is of Standard Oil fame, who gives his millions to institutions of learning and charity, is of a family who have been largely the clientelle of homœopathic practitioners, yet in this school of medical research about to be established under a board of directors, we find

that homœopaths are conspicuous by their absence. Inasmuch as I was chairman of the Bureau of Materia Medica, I took it upon myself a few weeks ago to write to that gentleman, requesting that in the establishment of this school of medical research he use his influence to have a bureau of drug investigation from a homœopathic point of view established in that organization. I have not as yet received any reply to my letter, but intend to follow it up and to try to get this Society in touch with that movement.

In the provings of the past, which were conducted before chemistry and the modern sciences had taken such tremendous strides forward as they have within the past few years,—those provings were undoubtedly at that time up to date, but now, with this tremendous progress in science, such symptoms as a brownish red sediment in the urine, or a brick dust sediment in the urine, or a reddish brown sediment in the urine, with which our materia medicas are so filled are very indefinite and very unscientific. To-day, when we have microscopes which are so perfected, and have among our numbers men who are so eminently capable of using these instruments of precision, it would seem that some movement might be organized whereby we could re-prove our drugs from a more scientific point of view. We have specialists now who are able to conduct these investigations and to investigate the symptoms produced by drugs so as to trace out their pathological importance; and in Brooklyn, as you have heard from Dr. Schenck, a very active movement is already on foot. In New York there is also a movement on foot. We have not heard as much from it as we have from Brooklyn. In all these large centers, New York, Buffalo, Rochester, Utica and all the centers of the State there should be established bureaus of drug proving so that we can prove these drugs, which are constantly being brought to our attention and being lauded so by the old school, to be cast aside in a few days as useless, so that we can prove these drugs, ascertain their definite action and add them to the fund of our materia medica. In New York during the past winter a little group of some ten or fifteen provers have been conducting provings in a fragmentary sort of a way, and we hope this winter to do a great deal more in a scientific way; and this group of provers have decided to prove drugs along a little different line than the provings in the past. We all know that belladonna, hyosciamus, almost all drugs of plant origin, contain upon chemical analysis a greater or less percentage of tannic acid, and we find running all through these drugs more or less common qualities, essential oils, active principles, so that when we come to prepare these drugs or try to study them, we find that their symptomatology is very confusing and intermixing, and it has been thought by some men that possibly this intermixing and intertwining of the symptoms of remedies is due to the fact that the tinctures of plant origin were so indefinite in their chemical formulæ and contained so many different qualities, active principles and essential oils, many of which are common to great numbers of remedies, that it has been decided in the provings to be conducted by this group of provers, that we

will prove active principles, qualities, essential oils, and compare them with the proving of the drug from which they are derived, and in that way try to work out a symptomatology and a materia medica which will be more definite. As to the raising of funds for conducting this work, it would seem that with a clientelle so wealthy as we know that of the homœopathic practitioners of this State to be, and so many of these followers of homœopathy having the members of their family preserved to them by the good offices of the law of similars,—it would seem at the present time, when everything is so prosperous and money so abundant, when the rich are seeking charitable work for the expenditure of their money, that we might turn some of that money toward this grand work of building up our materia medica. We very frequently hear, even among the homœopaths, of people giving large sums for hospitals or institutions of that sort; but hospitals only take care of the transient sick of the generation in which they thrive, while anything that we could do in the line of advancing science would benefit not only the people of this generation but would be a benefit to generations yet unborn. Another scheme which has occurred to me as a possible way of raising funds for the beginning of this work, in order that we may later show the public that we merit their bounty, would be for the members of the Society to appropriate possibly half the income of their practice on such a day as Hahnemann's birthday, and let us use that in these centers like New York, Brooklyn, Buffalo, toward the beginning of this work of re-proving of drugs and proving of new drugs.

DR. NICKOLSON: *Mr. Chairman*, this is a very interesting subject, but it seems to us that before we can interest the laity in helping us to prove and get our materia medica we should begin right at home, we should begin right here among ourselves. If we cannot interest ourselves so that we will have homœopathy taught to us, homœopathy discussed to us, in our Society, we cannot expect to get the laity interested. Only a very few years ago, in our International Society, we discussed diphtheria, and after it was discussed for nearly one hour, talking of different swabs, washes, &c., Dr. Butler, of New Jersey, got up on a chair and said, "For God's sake give us a little about homœopathy!" After one hour's discussion there was nothing said about homœopathy. No later than last fall one of the leading men in the state of New York and city of New York got up in this Society and said that the only thing to treat diphtheria with was antitoxin. Now, if we have come down to that, that we have nothing in homœopathy to treat diphtheria with but antitoxin, we cannot expect that men will give their money or their millions, or even their pennies, to help us prove homœopathy and prove our remedies so that we can get the similium. (Applause.)

DR. LESEUR: *Mr. Chairman*, this discussion is about completed, but I think every one of us who has listened to Dr. Crump has been impressed with two things,—one, that he has a definite purpose, and the other, that that purpose is thoroughly commendable. In view of those two facts I think the least we can do is to approve of the

action of this chairman and the work of this bureau. I believe every one of us feels sometimes a sense of shame that the work done in the department of materia medica is so inadequate. I think we like to follow that law of physics which makes it possible to pursue the line of least resistance and to find the easiest way rather than the most scientific way to the securing of that point which is the desideratum for the time being. We want the easiest and the quickest way to the end to be secured, and sometimes we take that course, mentally condemning ourselves, our medical conscience seared, perhaps, by our negligent practice,—we take the course which seems easiest rather than the course that we know to be right. That is, I say "we," because I am speaking now of myself and the Secretary (laughter)—I wouldn't like to be construed as including the whole Society—I wouldn't feel well enough acquainted with them. (Laughter.) But there are some who do that. I believe that we ought to be more industrious; we ought to be more energetic, and recognizing the utility of advantages that come as make-shifts, we ought not to lean upon our crutches always and lose the use of our legs. There is danger of that in the general practice of homœopathic physicians,—well, some of us, I say. I believe it would be wise for us to encourage this action on the part of this Society of provers by some general resolution that shall have with it the force of the concensus of the opinion of this great State Society. I, therefore, move, Mr. Chairman, that it is the opinion of this Society that the action of Dr. Crump in endeavoring to secure some financial aid for the prosecution of this work, has the approval of this Society. (Carried.)

# REPORT
OF THE
# BUREAU OF SURGERY.

"Surgery of the Ileo-cæcal Region," - - - A. B. VAN LOON.
"Care of the Intestinal Canal Before and After Operation," SHIRLEY R. SNOW.
"Weak Foot: Its Cause and Treatment," - - - - H. P. COLE.
"Where the Discrepancy?" - - - - - C. E. SAWYER.

## SURGERY OF THE ILEO-CÆCAL REGION.

A. B. VAN LOON,
ALBANY.

There is no portion of the intestinal tract which has claimed more attention in recent years than the ileo-cæcal region. Skilful operators and eminent physiologists have endeavored to explain the reason for the fact that there is an appendix. Volumes have been written expressing widely different views as to the proper treatment to be pursued when disease attacks it.

Probably the most frequent etiological factor in the production of appendicitis is catarrhal inflammation of the intestines in the immediate vicinity, either in the cæcum or colon, or ulceration of the same structures occasioned by grave constitutional disease. Traumation may act as an exciting cause as will be illustrated by description of history from my case record and thrombosis of the appendicular artery is probably the least frequent exciting factor.

The structure of the appendix closely resembles the colon, although it is perhaps more rich in adenoid structure; therefore, concretions and stricture from previous inflammation constitute an ever-present menace to the unfortunate individual thus afflicted.

The different varieties of appendicitis are arbitrarily stated varying in intensity from simple appendicular colic to thrombosis of the appendicular artery with consequent gangrene. It has always seemed to me that the division so common into catarrhal, suppurative and perforative appendicitis was somewhat misleading, for what appears to be the catarrhal case of to-day may be the suppurative or perforative case of to-morrow. If we could always be certain of just what the course of a given attack would be we could invariably institute the right treatment at the right time.

The symptoms which usher in an attack of appendicitis are pain, usually over the appendix, or if in other part or parts of the abdomen localizing itself in the course of a few hours over the appendix, vomiting, fever, and accelerated action of the pulse. However, in the appendicular colic we may have but one degree of temperature and but little acceleration of the pulse rate. It is in this variety of appendicitis where the pathological signs are nil that the opponents of early operation claim a mistaken diagnosis when such is really not the case.

In the catarrhal variety the symptoms are like the above, but here we have more fever and fast pulse, prostration and more rigidity of the right abdominal wall; the catarrhal attack, as does the appendicular colic, leads up to the suppurative variety characterized by suppuration and which if not stayed by nature leads to an abscess which may either be absorbed or break into the bowels or bladder or pleura or peritoneal cavity, in which latter case we have a general peritonitis.

The gangrenous appendicitis occasioned by thrombosis of the appendicular artery is the least frequent, fortunately, and the most serious and rapidly fatal variety of all and is ushered in by very rapid pulse, high temperature, cold, clammy skin, partial suppression of urine and restlessness or maybe coma. It is this class of cases that imperatively demand operation at once as soon as seen and frequently operation is unavailable even if done very early.

Any case having suffered from two or more attacks may be said to have the recurring or chronic variety. These cases often suffer from constipation and are frequently nauseated. Such individuals have an appendix which can never be safe company and often puts their lives in jeopardy. The diagnosis of appendicitis is not difficult, though when the symptoms are of a mild type, sight should not be lost of the fact that typhoid fever causes pain and tenderness, though not in so localized a spot as appendicitis and in the event of doubt a blood count to determine if a condition of leucocytosis is present will clear up the diagnosis.

The chronic variety has been mistaken for floating kidney, cancer of the cæcum, etc.

My plan of treatment has been to observe each case carefully, to individualize it. If we were obliged to commit ourselves to either—always operate or never operate—we would feel obliged to join the circle of those who always operate; but it has seemed to me to give patients the choice of waiting in cases that appear to be doing well is justifiable, especially as we, as surgeons, seldom see the case until two or three days have elapsed and often conditions of health and surroundings render the carrying out of ideal antisepsis impossible or impractical. Unquestionably could operation be done the first few hours of the disease in every case it would be ideal treatment; but that is rarely possible.

Many claim that medicines have no action in appendicitis but I always feel that I am committing no grievous error in administering bryonia or protidide of mercury or aconite or colocynthis if symp-

toms are present calling for these drugs in all but the gangrenous cases.

In conjunction with my medication I make use of hot water bag or ice pack if the temperature reaches 102°. If the pain is severe I believe it merciful to give narcotics guardedly, having first been sure of my diagnosis. Should nausea persist, nutrient enemata consisting of panopepton two ounces, normal salt solution one pint are highly serviceable.

I always watch a case where the pulse rate runs over ninety, for you can never tell when it may be necessary to operate; but a high temperature need not be the occasion of so much alarm.

As regards operative interference in acute cases, for we all agree the chronic or recurrent cases should be operated, in those with abscess formation with distinct tumor the incision should be over the tumor, dividing the muscles and aponeurosis as nearly as possible in a direction parallel with their fibers; having come down into the peritoneum the tissues adjacent will be found to be œdematous and dark colored if the abscess is adherent to the abdominal wall. In event of this being the case introduce the finger through a small incision in the peritoneum and feel cautiously for the appendix; if at any point the adhesions seem less firm than at other parts of the abscess cavity do not try to break up adhesions. If the appendix can be found and removed without breaking into the general abdominal cavity it should be removed, otherwise introduce drainage of glass or rubber, wash out cavity with normal salt solution and place gauze gently about tube and suture the wound. In all abscess cases not adherent to abdominal wall the vicinity of the abscess should be carefully walled off by gauze pads and the adhesions broken through gently with the finger or blunt instrument and evacuated, the cavity wiped out with normal salt solution and drainage tube inserted and gauze packed about it. If there are multiple foci of infection with pus it will be wise to introduce gauze drains to the several suppurating points, to be removed in twenty-four , thirty-six or forty-eight hours, as the case may be.

The incision made use of the recurrent or interval operation, in the class of cases just cited and in the cases operated in the early hours of the disease is as follows:

Starting at a point one inch above the middle of a line drawn from the anterior superior spinous process of the ileum to the umbilicus and about a one-half inch to the right of the rectus muscle and parallel to it, make an incision three inches long running down towards Poupart's ligament; when the superior oblique aponeurosis is exposed divide it in the same direction as its fibers. Underlying this structure we find the internal oblique and transversalis muscles should be divided again in the direction of their fibers; then e peritoneum in the usual way. If any adhesions are present e them and remove the appendix by making a circular incision it one-fourth inch above the cæcum, through its peritoneal ment; strip back the peritoneum, ligate the appendix, cauterize h carbolic acid crystals or actual cautery and stitch the reflected

peritoneum over the stump. It is well in every case before ligating the appendix to pass a probe through it into the cæcum to determine that its lumen is free; after this place intestines back into abdominal cavity and sew up incision with three layers of sutures.

For the first twelve hours after operation no nourishment by mouth is allowed and nutrient enemata or stimulation by rectum is given every five hours. Should gas not pass freely and if any distress is experienced, the rectal tube is introduced high up and if this does not give any relief the following is given in form of high injection: One egg. One-fourth drachm spirits of turpentine. One-fourth pound Epsom salts. Soap suds water qs. ad. oj.

This usually has desired results. After twenty-four hours milk is given, then broths and, if symptoms are favorable, solid food in three or four days. I wish to report two cases of interest, one the acute variety, suppurative in character with large pus formation, and the other the chronic variety.

H. A., æt. 14 years, was referred to me by Dr. Geo. Cox, of Albany. Patient had been camping out and fell while running down a hill with an alpine staff in his hand, the stick hitting him in the abdominal wall. His illness was uneventful and the symptoms not severe until I was called at the end of several days. I found large abscess in the right iliac fossa, which demanded immediate interference. The region of the appendix was filled by the abscess, tender and dull on percussion; the left side of the abdomen was resonant and the bowels had moved daily, temperature 102° and pulse 100. He did not see why he needed an operation when he felt so well. An incision was made parallel with the right rectus muscle down on the tumor. The tissues over the peritoneum were œdematous and dusky and the abscess cavity adherent to the abdominal wall. A needle was introduced for diagnostic purposes and pus withdrawn; an incision was then made through the peritoneum large enough to admit the index finger; no appendix or concretion could be found; two ounces of pus were then evacuated, the cavity washed with normal salt solution, glass drainage introduced and wound sutured. The patient was removed from the table in thirty-five minutes, cyanosed, with a pulse of 135 and temperature 102°. Under stimulating treatment the pulse dropped in six hours to 120 and in twenty-four hours to 100 with temperature 100°.

Wound was irrigated in twenty-four hours and thereafter night and morning; at the fifth day the glass drainage was withdrawn and gauze drainage substituted. The latter was discontinued after two weeks and patient made good recovery.

Case of M. B., referred by Dr. Paine, of Albany, had suffered from numerous attacks of recurrent appendicitis. I saw her in consultation during an attack and advised interval operation. The operation was done through small incision in the abdominal wall. The region of the appendix was found to be one mass of adhesions which were carefully separated but no appendix could be found; it had evidently been obliterated by the numerous attacks. The separation of the adhesions relieved the distress and tenderness in the right iliac fossa

and there has been no return. The abdominal wall was sutured with one row of suture and patient made rapid recovery.

This case illustrates how a number of attacks of inflammation may obliterate an appendix.

To sum up: I usually wait to operate if conditions warrant delay, and each case must be judged on its merits, until the attack is over and do interval operation. A pulse of over 90 should always be a cause for anxiety and a chill is an omen of rupture.

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## DISCUSSION.

DR. SNOW: *Mr. Chairman,* this certainly is an interesting subject and one that has been discussed many times in our societies. I do not think the surgeon is living who can tell to-day whether you have a thrombus of the arterial supply of the appendix or not, and one would infer from this paper that that is the only case that you must operate on immediately. I think experience shows us that the sooner we operate on a case of appendicitis the better result we shall get. The laity point to us as operating on cases of appendicitis and causing the death of the patient. The reason for this is that we operate after the physician has done everything in his power to help the case, and then brings it to us after it is beyond human assistance, and the large mortality attending those cases which have gone on to suppuration would be stopped if we took the cases earlier and removed the appendix within twenty-four hours after the attack. The doctor brings up a point in mentioning that he gives narcotics in a case of appendicitis,—I question that practice very much. If you give a patient suffering from appendicitis a narcotic you know nothing at all what your patient is doing. It hides the pain, and unless there is a tumor there you do not know whether your patient has typhoid fever, appendicitis or something else. Better let your patient alone, without narcotics. Take the appendix out before pus forms and save the surgeon a column article in the paper about somebody having appendicitis and dying from the operation. In those cases it is not the operation that kills the patient; it is the delay that kills him, more than anything else. About eight weeks ago I had a very good illustration of this. I was called out in the country to operate on a boy nine years of age. He had been sick two weeks with appendicitis. When I reached the place the boy was not in much pain. His abdomen was covered with a thick layer of antiphlogistine. I think antiphlogistine is a tip-top good thing, but it has its sphere of usefulness, and certainly appendicitis is not included in it. After examining the boy I placed him under an anæsthetic and made a small incision over the side and evacuated at least three pints of some of the foulest pus that one can imagine. The boy made a good recovery. He ought not to have done so, however, and I think if he had died the physician in attendance would have been responsible for that boy's death. Not only was there one physician, but he had

three others in consultation two days before, and they said, "Let him wait; there is no harm in waiting at least two days;" and I think if that boy had waited a little longer there is no doubt as to what the result would have been. Comparing that with a case where appendicitis has first started in and there is congestion of the arteries and no pus, the mortality is very light in those cases, and I think we may well say that most all of them will recover from an operation.

DR. VAN LOON: I would like to ask the doctor if he operates in every case he sees as soon as he sees it.

DR. SNOW: *Mr. Chairman*, I am perfectly willing to answer that question. If the patient consents to the operation I operate on every case. I believe that the operation within twenty-four hours after the diagnosis is made, saves a great many cases. I am perfectly willing to stand on that platform, of operating on every case of appendicitis as soon as the diagnosis is made. (Applause.)

DR. VAN LOON: *Mr. Chairman*, I stand on about the same platform, but we do not always see these cases as soon as they start. Regarding the condition of thrombosis of the artery, it always seemed to me in those cases it was well to go ahead and operate right away, take the chances of the doubt.

DR. SNOW: Just one word more. The doctor stands on the same platform that I do. I do not mean to say that a surgeon is responsible for the cases that he has not seen. We do not expect to operate on it before we see it.

CHAIRMAN WILCOX: This is a subject in which the general practitioner is equally interested with the surgeon and we should have a goodly discussion, and while we hear very much said about it, yet I feel that we cannot get too much of the subject.

DR. ROBERTS: *Mr. Chairman, Ladies and Gentlemen*, I am such a perennial talker on appendicitis that I feel rather ashamed to impress myself upon the audience once more. Still the subject is so wide and so interesting that it is very difficult for one not to say something upon it. I suppose that we all have different ways of looking at the same thing and different methods of accomplishing the same results. This possibly accounts for the wide difference of opinion and the amount of discussion and even sometimes disputing which will come upon the floor of a meeting like this. But I must take this occasion to disagree with the writer of the paper in a number of little points. First, he has spoken of thrombosis of the appendical artery as one of the causes of appendicitis. I doubt if there is one case in a thousand in which that is one of the causes. It would be a rare result indeed if we should get a thrombosis of that artery as the primary cause of appendicitis. It is one of the secondary results and when the artery does become thrombosed, we have a serious case of appendicitis. I agree heartily with Dr. Snow in his statement. I do not believe any one can tell when that artery is thrombosed and when it is not. I know of no symptom or train of symptoms that will tell us positively whether a given case is a serious one or not. There is the difficulty. It would be easy if we could tell.

The doctor has spoken about chill, high fever and high pulse. True, they are all serious symptoms when you get them, but a patient may lie in bed and get ready to die within half an hour, and have absolutely none of them. We are before a case, and we have the abdominal wall in front of this disease. We have only symptoms to read, and those symptoms have proven time and time again to be absolutely unreliable. Therefore, we are almost forced into the position which Dr. Snow has taken, that he will operate in every case at the time that he sees it. I think that statement is open to a little question. I think that perhaps I am as radical about that matter as most men, but still I do see cases where I am willing to wait a few hours; but it is very few hours. I do not believe you can wait twenty-four hours in those cases safely; and I feel, every moment while waiting, that I am carrying an enormous responsibility.

Speaking of the diagnosis of appendicitis, the statement has been made that the pain is over the appendix. That is not true in all stages of appendicitis, but you must remember that the pain of appendicitis is due to two causes; perhaps three causes, but two in particular. In the first place it may be a reflex colic, in which case it is located all over the abdomen. In the beginning of these cases we do not have pain over any point. There is general abdominal pain, which, in the course of a few hours usually settles in the region of the appendix. When the pain has located in the region of the appendix, it is usually because there is a surrounding peritonitis. That is, the inflammation has extended through from the appendix to the deeper abdomen, and now we have a local peri-appendical peritonitis. But beware of one thing,—with this general abdominal pain which you cannot account for in any other way, look at the case a few hours and watch the appendical region, and often you will find this pain locating there.

As to methods of operating, of course, we all differ. Every man has his own method of doing things, and I suppose that is the best method for him. I do not take quite the view of the operative measures which the doctor does. In the first place, the incision which he has spoken of is, to my mind, too near the median line. In these cases, if we wish to leave a strong abdominal wall, we must try to split the two planes of muscles in the line of their fibres, and those two lines come practically at a right angle; not exactly so, but taking the shape of the two crosses of an x. If the incision is as near the right *linea simularis* as the doctor has given us the impression, he will have very little distance to cut,—he said, I think, one-half inch to the right of the *linea simularis* formed by the junction of the aponeurosis of the transversalis and the internal oblique; and the moment you get to that point you reach the border of the rectus. If you undertake to lengthen this incision you have to cut the rectus fibres. That is objectionable. It is my judgment that it is better policy to make the incision farther out, possibly half way between the right anterior superior spine and the *linea simularis*. That gives you room for an incision which would be two and one-half, possibly three, inches, in

length, through which incision you can make a great deal more manipulation than through the shorter one.

Now, as to what to do with this abscess. If in making an incision through the parietal peritoneum we get into the abscess, all right; then we can enlarge our incision to the full extent of the abscess in one direction and another and clean it out. Then the question arises whether we are to treat the case from that point on, as the doctor has described, by drainage, leaving the appendix, or shall we go ahead and try to find the appendix? Theoretically, it is a dangerous thing to drain a pus cavity, or an infected cavity, into the general peritoneal cavity, but practically, in appendicitis cases, we can do it with perfect impunity. That is a strong statement, but it is true, if we do it properly, and the method is perfectly simple. When this cavity has been opened and the pus is washed out with any of the stronger antiseptic solutions, that is washed out and we get rid of the macroscopic pus. If we stop there we are going to leave a diseased appendix and we are going to leave just as badly diseased an appendix as though there never had been any pus formed, and we all admit that a diseased appendix is a bad thing to have in the abdomen. In the early part of my operating I left some cases that way, and I have one case whose death is absolutely due to leaving that appendix. Now, the appendix is very easily gotten in the large majority of cases. The way to do it is this: The walls of that cavity are made up of folds of intestine and omentum. Simply tear that wall to pieces and you will find the appendix. I do not believe the appendix is obliterated once in a hundred times. You dig down, and all at once you get the whole mass, and separate off your appendix just as perfectly as though it never had inflamed, and you will usually find a little perforation of its wall. I have a dozen of them in bottles at home. So I think it is wise to get the appendix every time, unless the patient is in a very serious condition. I have seen cases so bad that I would not care to continue the anæsthesia, but those cases are rare. If when we make this incision in the peritoneal cavity we do *not* get into the pus cavity but get into the *general* peritoneal cavity, then the method is, as the doctor said, to pack the gauze around these adhesions, gradually separate down until you get a very small opening into the x pus cavity and control the pus by wiping it out rapidly with a sponge when it is coming out through the small incision. Don't make a large incision, because if you do your whole field will be flooded with pus. If you make only a small incision, it will come out a teaspoonful at a time and is readily handled. Then this mass is torn apart and the appendix taken out. After that, don't, for heaven's sake, use the glass drainage tube. The glass drainage tube went out of existence, so far as abdominal surgery is concerned, a number of years ago. It is bad from many points of view. It is much better to use the gauze drain, covering the gauze with rubber tissue so that it does not become adherent. Simply leave one end of the gauze projecting and put it into the depths of the wound. Then a large mass of very absorbent gauze on the outside of the

abdomen, keeping up capillary attraction, produces currents from all over the abdominal cavity. The mass of intestinal surface falling together forms capillary tubes just as the layers of gauze do, and that will keep currents from all around the infected area toward the surface; and there is in those cases practically no danger of general septic peritonitis.

Just a word more. There are a number of other little points on which we may differ in treatment, but they may pass. This whole subject, to me, in a given case, comes right down to a few sentences which I have given, I think, in these meetings once or twice before, but I want to repeat them. In a given case of appendicitis we either have pus in the appendix and about it, or else we do not have pus there. There is no alternative. If there is no pus there, and we have an appendicitis, every one of us knows that there is practically no danger to removing the appendix. There is practically no danger to the laparotomy which has for its object merely the removal of the appendix. We may, of course, get a death once in a while. We may lose one case in a hundred, because we cannot cover all the possibilities of septic infection. It is possible for a nurse or some one else to make a mistake and infect even a clean case; but taking things by and large, we ought to be able to remove one hundred non pus appendices without a single death. That is one side of the case. Now, if this case has pus in it, I want to ask the members here which they would rather trust themselves to, the knife of a surgeon,—if you have pus in your abdomen and you know you have,—or would you rather take medicine for it, or take any method other than the surgical one? To my mind the question is answered. In either case the safer thing is to operate.

DR. SHELDON: *Mr. Chairman*, of course I arise to say something in behalf of the general practitioner, because we have a good many hundred general practitioners to one surgeon, and if I were a young practitioner listening to the discussions upon the treatment of appendicitis, I should become so timid and fearful of my position and my ability to treat a case, that I should at once ask the parties in authority if I couldn't leave. But I have not been accustomed to retreating. Now, the doctor says that he believes the mortality would not be beyond about one in a hundred if they operated in every case in the early stages. Well, I would like to know what the doctor would say if the general practitioner treated a hundred cases and lost but one. It would be an even deal. As I said before, I have listened to these discussions so many times that I feel as though the general practitioner has simply stood back and left it all to the surgeons. I do not ignore early surgical treatment. I do not ignore the work of the surgeon. I know that it is right in many and most all cases; but when we realize the fact that from twenty to fifty per cent. of the cases will recover under general treatment, or general practice, under the hands of the general practitioner, I believe that the general practitioner should have something to say about it, and tell something about the means he uses and whether he believes in the remedies or not. Not long ago I was called to

see a little child, five or seven years old, a delicate, beautiful little girl, and I became satisfied that she had appendicitis. A surgeon was called, who examined the case thoroughly and advised an immediate operation or they would lose the child. Well, the child is alive and all right, and they didn't operate. But that is no reason why the surgeon's opinion in these cases is not valuable. I believe that many of the cases that do die under surgical treatment are not operated on soon enough, and I think that many times, no doubt, one great fault on the part of the general practitioner is that he delays and dallies and waits in the hope of overcoming the symptoms as he would in the ordinary case of colic or some other intestinal trouble, until it is too late. And then, on the other hand, I believe that the surgeon, when he says he will operate on every case,—that he would operate on fifty per cent. that did not require it, and possibly lose some of those that the general practitioner might save. Now, there is a happy medium in this thing. The surgeon is all right, and the physician is all right.—(Applause.)

DR. TERRY: Most of the gentlemen of this Society, and of the medical profession of this country, are familiar with my ideas in regard to appendicitis. I certainly have not hesitated to give vent to my feelings. I believe that I differ from a good many, and that difference is based on my own experience. I have not borrowed it, and I will give it to you now, subject to your criticism. In the first place, I believe that constipation is the primary cause in nine cases out of ten of appendicitis. I believe that the way to prevent appendicitis is to regulate the bowels. They should be moved with the same regularity that we take our meals three times a day; and, of course, the best time for the movement of the bowels is before or after breakfast, because if we wait, delayed by callers or by business, we break up one of the habits which has to do with keeping in good health. The question of the comma bacillus, or microbes, causing appendicitis, to my mind is absolutely absurd. Absolutely absurd, because there is not probably an individual in this room that has not microbes circulating from his mouth through to the end of the intestinal tract. That is simply an incident. Now, with the regulation of the bowels, let us come down to an acute attack of appendicitis. I refer to every form of appendicitis, whether it be acute, culminating, recurrent or a pus case. The remarks of my friend, Dr. Roberts, on the left, were certainly very interesting. The operative procedure, as he performs it, is certainly valuable, but it is not so easy,—I do not believe that Dr. Roberts pretends that he is able in every instance to absolutely diagnosticate a case of appendicitis, as to whether there is pus or not. If he does, he can do more than men like Dr. Morris, whom I taught for two years, but never have seen the gentleman—he has made mistakes, and they are in print,—and I have followed him very closely. Now with the report of the cases published by Dr. Clark, of Johns Hopkins University, to the number of 700 cases of laparotomy, we have his observation that the peritoneum, if untouched, is capable of absorbing pus in all sorts of

foreign bodies; with the ability of the peritoneum to absorb from one-eighth to one-twelfth of the entire body every hour, we see what we have in the way of a suppurative appendix. I am not saying it is not good surgery to cut down on the appendix in the early stage if you have so good a surgeon as Dr. Roberts; I am not saying it is not the best thing under all circumstances; I am not saying it is not the best thing in children; but what I am saying is that it is not the best thing in my judgment to do it. I have had cases come into the hospital,—and there are surgeons who come to this hospital who are as heroic as my friend, Dr. Roberts,—who have operated on pus cases, who have operated on children; they have had more than 1 per cent. of deaths. The American work of surgery takes it that the average per cent., taking all cases, is about 8, from that to 12; we cannot get all these cases in the first instance without pus. Pus, as Dr. Roberts knows, is formed under twenty-four hours. I have seen cases, I have been connected with the operations, where pus was shown and there was a sloughing appendix within twenty-four hours. Why, the last case I operated on,—I will detail it to you, a young man whom I visited in Princeton College. I was wired as to whether I would take the case because the surgeons there were unknown to the parents, who lived in Missouri, and I immediately visited the patient at the infirmary at Princeton. The young man was suffering agony and I could scarcely touch his abdomen. Of course I did not go through all the detail of diagnosticating because it was too evident. He had a very high temperature and rapid pulse, and it looked to me like an operative case, and I presume some of these surgeons would say I was an idiot for procrastinating. I got everything in readiness for operative procedure and proceeded to go through the operation, which I will now detail. It is familiar to most of you, perhaps, but I will give it to you. I gave that gentleman a tablespoonful of sweet oil in a glass of hot water every three hours. I put him on aconite, five drops in a glass, put ten drops of bryonia in another glass; five drops of bryonia and ten drops of veratrum in another. He was given those remedies half an hour apart. A poultice was applied over his abdomen, a large, juicy poultice. The abdomen was swathed in sweet oil, the poultice placed over and kept hot and changed frequently. He was given a colon enema very carefully, and one must not use too much, because you may rupture the appendix if it is very far advanced. We cleansed out the lower bowel. Half an hour later he was given an enema of sweet oil, six ounces of sweet oil, two ounces of elixir. That was the treatment. He was watched carefully. If a case does not get better within twelve hours, if a case gets worse under me in three hours, I should certainly make my preparations for operating. But this man, although he had had attacks for eight or nine years, on various occasions, recurring attacks,—every surgeon I know of insists that those cases should always be operated on, though I believe that all surgeons agree that an interval operation is the safest. I thought if I could carry him through this operation, in view of the fact that he is going to be

connected with the mines in the West, it was the better thing to do. Within twelve hours the pulse was coming down, the temperature was coming down, the intense soreness and pain decreased, and to make a long story short, within three days he was put in a barouche and taken to his home, and in two weeks he was on the street. As a mining engineer his life will be a rough one, the diet, whatever he can get, and he thought it was best for him to be operated on. I did the muscular operation of which Dr. Roberts has spoken. I found that the appendix had ruptured, that the end of the appendix was attached to the omentum, completely closed; but here, gentlemen, comes in the wonder of the oil feature in this treatment,—because, remember, we are nothing but a piece of machinery with a vital force, a body of which we know but very little. The appendix was kept open by the oil insinuating itself. The pus had given itself vent through into the intestines. As I said, the appendix was closed, and the man was well. It was a good thing to operate on this man; but there you have a rupture of the appendix and the man's life was certainly saved. He would have been saved had he lived in Utica. But I still approve of the operation. If my other operation could be done in this intermuscular method, as described by Dr. Roberts, one of the great dangers of operation would have passed away, but unfortunately they are not performed in that way, whether you do the one and one-half inch incision or not. A certain percentage have hernia, and that is a very annoying affair, and, therefore, if we can cure by medical means or mechanical means,—and Dr. Sheldon has shown good success in that method,—I think it certainly is good treatment. I have never lost a case by pursuing this course, and I think if persons, after they have their attacks of appendicitis, will remember one of the great causes of appendicitis, that constipation is at the bottom of it, if the sediment, which forms the basis of foreign bodies in the appendix is kept away by regularity of the bowels, the appendix will perform its little office, whether it be as a lubricating organ, ileo-cæcal valve, or not, which Dr. Hale, I think, at one time suggested. Now, suppose your case does not get along nicely by the taking of the oil internally, but you see some improvement. I then carry out this line,—every three hours taking the oil, as improvement takes place, three times a day. The colon enemata are continued for five days. Now I am taking for granted that the case is coming along nicely. The colon enema is given perhaps at ten o'clock in the morning, or at some time during the day, and every night the colon enema is also given with sweet oil for the purpose of lubricating and relaxing the parts, and that machinery will certainly be reduced to its normal condition to all intents and purposes. If, however, it is a recurrent case in which these occurrences have taken place over a series of years, I give calomel and soda; generally half a grain of calomel and three grains of soda, in connection with the sweet oil. That has the effect of reducing the thickening of the appendix and the region about the appendix, producing absorption. That, in outline.

Now, in reference to the diet. When the case is brought to the hospital,—I move them wherever they are, in Utica,—I do not hesitate to have them brought there,—they are taken off of all kinds of food. They are given nothing but hot water, and just as soon as improvement is manifest and the temperature has dropped down to approaching normal, they are given strained oatmeal gruel, to which is added a small quantity of salt. That is all they have until the temperature is normal. Then, of course, we begin on the moderate convalescent diet. We have in connection with our hospital some young gentlemen who have been reared on the teachings of some of the most heroic surgeons in New York City. They came to Utica, connected themselves with the hospital, thoroughly convinced that there was only one way to cure appendicitis, and that was with the knife. They had their surgeons to operate. They lost their cases, in the various stages; and we have good surgeons in Utica. They are not all living in New York City (laughter), nor in Rochester (renewed laughter),—and I will say we are proud of them in each of the cities. But the cases get along nicely, gentlemen. These surgeons of the hospital have slowly come to the conclusion that it is not the best thing to operate on every case at the hospital; because if you get an improvement within a few hours, if the pulse goes down, your temperature goes down, gradually, it is an indication that a case in nine times out of ten will get well. My experience has been that out of fourteen or fifteen, fourteen to fifteen will get well under this treatment. Now, as to whether or not these cures are permanent. They are just as permanent as the cure of indigestion is permanent, unless you eat mince pie the second time. You may give your indicated remedies, but you will have dyspepsia again if you are foolish enough to eat these injudicious things. You cannot adopt the diet of an ostrich and have a good stomach. It is just so here. Regulate the bowels and keep them regulated, and I do not believe you will ever have a case of appendicitis,—I will put it stronger.

DR. SNOW: About two weeks ago I was called up at 11 or 12 o'clock at night by a man at the 'phone who lived about five miles away from the house, who said his little boy was very sick. I told him I was all tired out,—I knew the boy pretty well,—and asked him if he couldn't come over to my office and get some medicine instead of my going over there. He said, "Why, don't you know my history?" I said, "No. What is it?" "Why," he said, "I went down to Utica a little while ago to bury my mother. While down there I was taken with an attack of appendicitis. The doctor down there gave me the oil treatment." I said, "How are you now?" Said he, "I can't get over to the office; I am as sore,"—the ladies are here; I will not say how sore he was. I am going to watch that man. The next time he eats a piece of mince pie I am going for him. (Laughter.)

CHAIRMAN WILCOX: I just want to say a few words, indorsing again the early operation. I say it frequently and often, because I

believe in it thoroughly. Dr. Sheldon has admitted that there are certain cases where there is no question at all but that the general practitioner, in whose hands the case perhaps first appears, waits too long, and at the same time he tells us of those that he has cured by medicine. Now, the question is, How are we going to know whether we are waiting too long or not? If there was any pathological process by which we could recognize the tendency toward suppuration, gangrenous or otherwise, in these cases, why, it would be perfectly safe to wait. But there is no process that we can recognize in any way whatsoever. It has no recognized pathological process. We take our chances every time we wait over twenty-four hours, and it has been proven over and over again that the early operation is exceedingly simple, that the operation upon a non-inflamed appendix amounts to very little indeed, and there is no doubt that ninety-nine per cent. of such cases do recover. We do know, however, that the moment it goes beyond the ordinary inflammation, it goes on to a suppuration in the first stages, to interstitial inflammation, gangrene,—we know that then it is an exceedingly dangerous operation, and the only safety lies in the early operation. Now, there is this very great advantage always in operation. If it were like certain disease in which by the operation we simply averted this one attack, and the attack would be likely to come on again, we have not accomplished a great deal; but when we operate and remove the appendix, we relieve that patient forevermore from the danger of having appendicitis; and we do know,—whether it has become more frequent than formerly, I cannot say, but it seems to be so,—that patients that have had one attack are very much subject to recurrent attacks, and if you are successful by the oil treatment, by medicinal treatment, by treatment short of operation, you have only helped them for the time being. They are almost positively sure to have another attack, and it is quite likely that in the subsequent attacks they will have it more severely, until finally the operation has to come, and in all probability that operation must come during the most severe part of the attack, when it is exceedingly dangerous. I want to endorse at every possible opportunity the early operation as being the only safe course, because it is safe at that time, and we do not know what cases are liable to go on to suppuration.

DR. TERRY: I do not believe there will ever occur a case of gangrene of the appendix if the oil treatment is instituted at once. I do not think it is possible. You cannot even have a case of strangulated hernia with the oil treatment. I would like to speak about that. It is simply impossible. You get this relaxation, and therefore you do not get the strangulation. I am not like Dr. Wilcox. He thinks God Almighty left the appendix there by mistake; thinks that it should have been cut off, but He didn't have time, and therefore he oughtn't to have it. I don't think so. (Laughter.) The general statement he makes, that when you cure an appendicitis without operation you do not cure it for all time, is absurd, and I have proved

it time and time again, and I have been at this racket quite as long as Dr. Wilcox has, for thirty years now, and my experience is as good as his. He may do ten operations to my one, but my judgment ought to be proportionately good. If he will come to Utica I will take him around from house to house and show him a great many persons who have never had a subsequent attack, and why? Because they have been instructed in physiological laws; they know how to take care of their bowels; they know how to eat; they do not have the obstruction of the bowels. Take off your appendix. You will get obstructions there, and you will get all sorts of distortions and contractions; you will get sigmoid disease and God knows what. Now, I say, regulate your bowels and your diet; and you surgeons, instruct your patients, instead of just saying, "Take care, there is a little smothering volcano in there that must be taken out or you will never get well." You don't dare to get married, even, because you will have an explosion the first thing you know. I tell you, gentlemen, that is the key note of this whole appendicitis business. Go to the surgeons who are living by these operations; that is all right, but when your patients do not allow you to operate, you try the oil treatment and you will put your knife in your chest again and go home and say, "Well, that is a pretty good thing after all." (Laughter.)

DR. SHELDON: *Mr. Chairman*, may I say one thing? We old fellows die hard!

DR. ROBERTS: I agree with Dr. Terry in the early part of his discourse, and I like to hear a man take the position that he does. He is absolutely earnest about it, just as earnest as we are, and entitled to just the same consideration. That constipation is one of the principal causes of appendicitis, I have not the least doubt. I believe that Dr. Terry is entirely right about that, and I believe that if we could teach the public to attend to that matter properly, we should lessen the number of cases of appendicitis very materially. But I defy anybody with less persuasiveness than Dr. Terry to take the majority of men and women in this country and teach them to keep their bowels in proper shape. It is a very difficult matter, as you know. There is sometimes a question in my mind how much constipation has to do with this matter, for the reason that we find appendicitis to be considerably more common in men than we do in women, and on the opposite side, we find constipation to be much more common in women than we do in men. Is that not true, Dr. Terry?

DR. TERRY: I am not prepared to say at this moment. I would want to think about it a few moments.

DR. ROBERTS: Well, you think about it a few moments, and I think you will agree with me. Now, the doctor said, among other things, as a rather wonderful thing, that we had microbes from the mouth clear through the intestinal tract. Of course we do. They do not do any harm. Nobody ever pretended that they did. Nobody has ever pretended, to my knowledge, that the presence of

the colon bacillus in the intestine was anything but physiological. I am not talking about the presence of the colon bacillus in the peritoneal cavity. That is another matter. I am talking about the intestinal tract. As to the absorption of pus by the peritoneum, nobody has denied in recent years but that the peritoneum would absorb a certain amount of pus. No one pretends that we do absolutely aseptic operations. We do undoubtedly introduce some germs and the peritoneum takes care of them; but I do not want personally to try the experiment of putting any amount of pus in my peritoneum, nor do I want to put it in the peritoneum of any patient, and the route which will take the pus directly out of the peritoneal cavity is by far the safer, and the more certain that route is, the more certain is our cure.

Now, in relation to the cure of these cases by the use of oil, I want to ask one question in earnest. Take one of these cases,—I have no doubt he has seen them—I think we all see them,—where you get a concretion in the appendix, and above that concretion is a stricture. Now, those are among the most common gross pathological conditions we find in the appendix. The usual thing in these old appendical cases is to find one, two or three concretions, and above those a stricture which will absolutely prevent their coming out, and sometimes such a firm stricture that you cannot get an instrument through it. I want to ask the doctor how under the sun, when pus forms below that stricture and in contact with the concretion, which is the usual place for it, and when you have ulceration there,—how is oil going to affect it? Now, it may be that in your experience it does, but you know, doctor, you can't expect us to accept this statement as conclusive,—"my experience." You have got to demonstrate a reason for it. I wish the next time you speak on this subject you would just explain how that occurs, because I cannot understand it, and I think that is the great hitch with all of us, in understanding your position in relation to this matter.

DR. LEE: *Mr. Chairman*, there is a good opportunity to teach a practical lesson just at this point, and I rise to speak a few words. Dr. Roberts spoke of the strictures of the appendix and the concretions beyond it. These are the dangerous conditions that the surgeon meets in most every case in which an operation is necessary. What I want to do is to make perfectly clear to the physicians present what usually happens at that time in the way of symptoms. Now, the first thing that is noticed is the colicky pain in the right side; it may be over the gall bladder and not present at all over the appendix. It may be on the left side of the body and but little pain over the appendix. You may not be able to develop any sensitiveness over the appendix at this time, but nevertheless the appendix is now gradually distending, pus is forming, and we get at this time a pain. You may administer this oil, and about this time the appendix perforates. This poisonous matter passes out into the peritoneal cavity, usually occupying a small space about the appendix, and the symptoms subside. The pain disappears to a very great

extent, the fever comes down, if it has been as high as 102, to nearly normal, the patient says he feels better and the friends are relieved. The family physician says, "Well, he is getting well." He is doing nothing of the sort. He has had a little relief from the trouble with the appendix which has caused distension in the side, but pus is forming about the appendix. If the patient is fairly healthy nature will throw out her barriers and the pus will not be distributed over the abdomen, and a localized abscess takes place, and finally it is opened by the surgeon, and it is a very simple matter. He gets well. Now, in other cases, the most dangerous of all, this pus is not localized. It spreads to the pelvis, in fact, in quite a number of cases involving the promontory of the sacrum, and has to be reached from the pelvis and brought up and removed. In such a case as that you will probably find a pint of pus in the pelvis, and back on the right side of the abdomen above the appendix there is possibly another pint of pus, and in still other cases it is through the entire abdomen. Now it is in these cases where the danger is present. It is not in the catarrhal cases that oil will cure. But it is in this class of cases, which I am sure the General (Terry) will acknowledge call for the most prompt action on the part of the surgeon. I question not that he would operate on those cases, the same as we would, but in his desire to teach the profession due conservatism he has made the mistake of giving out the impression to the physicians present that he would not generally operate on appendicitis, and hence these cases will go on and all of them will die. Now, this is what I want to get at. When we come to a condition like this, isn't this the question that we want to get at this morning, What shall we do? Shall we apply oil? Shall we give the indicated remedy? or shall we operate? I cannot tell you what to do, but I tell you what I would do. When I am called to a case like that, after the consultation,—for it is generally in consultation that I am called to such cases, as I have none at all except in consultation work,—after we have decided what course to take, we call the father, or the mother, or the responsible person. Now, understand, in some of these cases after perforation it is impossible to make a diagnosis of appendicitis, to make an absolute diagnosis, and that seems strange. There is nothing that you can feel in the abdomen at all. There is no swelling in the right side, because nature has not been sufficiently strong to throw out her barriers and to create a swelling. The pus is in the pelvis, or it is on the right side back of it, or in the cavity of the abdomen. There has not yet been time enough for the septic conditions to develop and tympanitis to occur. The patient has some rise of temperature perhaps, perhaps none at all, or it may be sub-normal. Now, what shall we say in a case like that? We must first be conscientious ourselves. We must be honest with those people whom we are trying to relieve; we must be honest with ourselves. I say this: "Mr. Blank, it is impossible to make a positive diagnosis in this case. Nobody can do that. The chances are ninety-nine out of a hundred that this person has appendicitis. Now, if we wait forty-eight hours for positive

symptoms to develop, so that we can say to you that the case is one of appendicitis, we will have lost fifty per cent. of our chances to save the patient. If we go on and operate, make an exploratory incision, and there is no appendicitis at all, which is only barely possible, we have put this patient in only one per cent. of danger. If we operate now, before perforation takes place, the chances are ninety-nine out of a hundred that the patient will get well." I have never placed these facts, or what I believed to be the facts, before the family or the patient in that way in my life that they did not say, "Well, doctor, we don't know; you can go on and do what you think is best." The surgeon is then in a good position. He can go on and make that exploratory incision in perfect honesty, and in ninety-nine times out of a hundred, I may say, with the practical surgeon, —I will put it ninety-five, to be sure,—he will be right; he will find the conditions as I have explained, but he will save the patient's life.

In another class of cases the man is at his work. He has felt very little pain in his right side, possibly none at all; at least none that attracted his attention. All at once, while engaged with his usual occupation he feels a sudden pain, and is stricken at once. He is taken to the house, the family physician comes in, and he calls that colic, he calls it a bilious attack, he calls it gastralgia. Now, it is none of those things. That was perforative appendicitis. The perforation was the very first symptom that that person had of his illness. You cannot give oil in a case like that. Gen. Terry doesn't give out the impression that he will give oil in a case like that; but, as I said before, he has created an impression here before these physicians which he does not want to go out, namely, that most all of these patients can be cured by the oil treatment. He wants to give out the impression, I apprehend,—is it not so, Gen. Terry?—that we want to apply remedies where remedies will work best, and the knife where the knife will work best. I speak of this in this way because I know from private conversation with the General that that is just exactly what he means to do; but in his zeal to teach a proper degree of conservatism he misled the gentlemen and the ladies present, and it is a bad thing for the cause, and I want to have it understood that that is not the position he takes, and I want to give him the opportunity to correct it, and I know he does.

DR. TERRY: *Mr. Chairman*, I certainly cannot object to the statements and the position that Dr. Lee has taken in reference to appendicitis,—do not wait. But when Dr. Lee makes the statement to the family, suppose they do not always say, "Doctor, do the best thing," but they say, "Well, now, we will wait. May not this be colic?" Many a surgeon has made that mistake. But my point is, put your patient at once upon this treatment if you are obliged to wait, and my opinion is that you will defer many an operation. Now have I made myself clear?

DR. ROBERTS: If you are not obliged to wait, what will you do, General?

DR. TERRY: I have no objection to any surgeon's proceeding with

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the operation; none whatever; but, gentlemen, we are not all surgeons. There are over 100,000 physicians in this country. What percentage of them are surgeons? Could you operate on every case of appendicitis which occurs in this country? I imagine not. You cannot do it; and I know from some experience that a very large percentage of these cases are curable. I have no instructions, I have no suggestions to make to Dr. Lee, nor to Dr. Roberts. I think Dr. Lee has rather overdrawn me in reference to what they shall do under given conditions. I do not think that Dr. Lee will make any mistake when he takes his knife. I don't think Dr. Roberts will make any mistake, I don't think Dr. Wilcox will, and I might name other distinguished surgeons of our school, all of whom we are proud; but, gentlemen, these cases are spread all over this country of about 77,000,000 of people, and they come before every physician who is practicing. The question is what to do before your surgeon arrives; what to do when he does arrive, when the family cannot make up its mind. Let me illustrate this. I was called into the country here within ninety days by a good Irish family, to see a man who was awful sick. His temperature was 102½ and 103, and they had a nurse in the house. I looked around for the kitchen to get things ready for an operation, when they said, "Well now, hold on, doctor. Such a one down here, they operated on, and they died. We got you because we heard you got along without any operation." "Well," I said, "I operate in conditions like this, and I think it is the proper thing to do." Well, they began to question whether to operate or not. My judgment was to operate; and as in many other cases, I wanted to operate there but they wouldn't let me do it. That is why I have had this unique experience. Well, to make a long story short, they said, "We think we will try this oil treatment." I said, "Madam, you will take your chances, then. My judgment is to operate." The man got well and he is attending to his farming now. That is only one case. Now I will tell you of another,—I will go clear to the very extreme in regard to a case of appendicitis. Another case in the country, a girl sixteen years of age, so far advanced in appendicitis that I felt the jar of walking on the floor would almost produce rupture or death to the woman, because her heart was 140 or 150, temperature away, away up to 103 or 104, and I thought she would certainly die. I said, "Doctor, I don't think you can do anything, but just give the patient what you can of the oil, and do everything gently." That patient walked to my office in three months. Now, I am not advising this, understand. I am merely saying, when you get a case of appendicitis in the country, don't fold your hands as most surgeons do. If a surgeon like Dr. Lee says operate, operate. That is all right; but you can't all have such surgeons as this. Instead of folding your hands, carry out this treatment, which I think is one of the greatest that ever was devised for appendicitis, because I have carried it out for fifteen years, and I know what it will do.

Now, in answer to Dr. Roberts, in reference to the male and female

side of this question. The man has to work very hard, his brain is away up to the highest tension, and physically and psychologically he is up to the highest pitch. He eats more heartily than a woman. And a woman is a creature of relaxation. God Almighty made her so. She does not eat so heartily. Her system is so constructed that she is obliged to relax, and, therefore, she does not have appendicitis as readily as a man. When a man gets sick everything is at the highest tension, inflammation runs to the highest point, and that, in my opinion, is the reason that when a man comes down everything contracts at once, whereas a woman hasn't all this inflammatory material, doesn't take her cocktail every three hours, her soda mint at night, and that is the reason we notice this great difference between the two. Otherwise I think it would be about the same, and I think in favor of the woman having it the more frequently.

DR. VAN LOON: *Mr. President,* I do not feel that it would be proper to say very much just now. You have all heard enough. But I would like to reiterate the statement I made in my paper. I feel that if I were obliged to attach myself to any given circle in regard to operative interference, it would be the circle that always operated. I think, however, that there are many cases where delay is safe and is wise. I want to thank Dr. Roberts and the other gentlemen for their very kind attention to the subject.

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# CARE OF THE ALIMENTARY CANAL BEFORE AND AFTER OPERATION.

SHIRLEY R. SNOW,
SURGEON TO ROCHESTER HOMŒOPATHIC HOSPITAL.

The recent article of Dr. Roberts upon the use of a cathartic preceding operation is so replete with authorities quoted that it leaves no doubt in the mind of the reader as to its general acceptance. It is not for the purpose of refuting any of the arguments advanced in this paper that I refer to the subject at this time, but rather to learn from the discussion some method to mitigate, if possible, the uncomfortable and sometimes alarming symptoms following the administration of an anæsthetic for operation.

There are two classes of cases with which we meet: First, the emergency which require immediate attention, that is, within twenty-four hours, and second, those which can be kept under observation and treatment a few days before the operation is performed. Unfortunately, the latter form a much smaller class than the former, due, in part, to the nature of the disease and in part to the disposition of the patient. After an operation has been determined upon the

sooner it is performed the surer we are of the results, as we well know the disturbance to the nervous system of the patient by the thoughts of an operation, and the disturbance to the surgeon by the tendency in the patient to consult with the omnipresent neighbor and the always available but deplorable "bargain counter."

It is a pretty well established fact that the line of treatment for those who can wait should be as follows: The bowels should be opened by a mild cathartic or aperient water and kept so for a week; water should be taken freely, thus flushing out the kidneys and freeing the body of its poisonous substances. The nourishment during this time should be highly nutritious, at the same time easy of assimilation. As much exercise as is practical should be taken, the aim being to get the body into as good condition, physically and nervously, as possible. Unless required, stimulants should be withheld. During the last twenty-four hours all nourishment, excepting possibly liquids, should be stopped. The morning of the operation a purgative enema should be given. This last procedure, however, I believe productive of nearly as much shock as the use of a brisk purgative.

The other class or emergency cases do not give us time for this careful preparation. Many of them have suffered severe shock from accident, but experience shows us that they suffer less from alimentary disturbance afterwards even than those who go through the course described above. It is then, as Dr. Roberts suggests, the abdominal cases which interest us the most. It must be admitted that many make an uneventful recovery even without former preparation, and that others who have had a cathartic suffer much from nausea and inactivity of the bowels. This is due to other reasons than the mere use or non-use of a cathartic. It has been my experience that the male suffers less from nausea than the female. The nervous woman is more affected than the strong man. Again, the length of the operation, the amount and kind of anæsthetic administered have their influence. The more the intestines are handled the greater the disturbance afterwards, but that which seems to have the most influence is the operation upon the organs which act reflexly upon the stomach, such as the uterus and ovaries. This would tend to show that there is a large nervous element in the ill effects of the operation and our efforts must be, in part, at least, directed toward the nervous system.

All operators will agree upon the great advantage of having the intestines free from gas and fæcal matter at the time of operation, as they are much more easily held out of the way and nothing interferes more than the persistent attempt of a loaded bowel to crowd itself into the site of operation. Relieving this condition more than counterbalances the ill effects of the cathartic. I doubt then, that, after the subject has been discussed from its various standpoints, the use of a cathartic be discontinued.

Whatever be the care given a patient preceding operation, we still find ourselves confronted by untoward symptoms, afterwards, in a

certain number of cases. Perhaps the most distressing one during the first twenty-four hours is thirst. This is difficult to relieve; water taken into the stomach increases and tends to prolong the vomiting. It may be given in small quantities, hot or cold, beginning ten hours after the operation. It is argued that a brisk cathartic dehydrates the body, so to speak, aggravating this thirst. It has been my experience that water can be given earlier to the cases that have had a cathartic. If the bowel has been emptied, normal salt solution will be absorbed more rapidly from the intestines, supplying in part the water required by the system.

It has been pretty conclusively shown that at least part of the thirst is due to the effect of the anæsthetic upon the mucous membrane. It is upon this ground that inhalations of vinegar or acetic acid are used immediately following operation. Whatever the theory may be on this point, practical experience shows that the use of vinegar not only lessens the thirst but also has a beneficial effect upon the nausea and vomiting. As soon as the stomach will tolerate water it should be given copiously in order to flush out the kidneys and bowels.

The inactivity of the bowels after an abdominal operation is often a perplexing problem. I do not think this can be attributed to catharsis, except so far as their being cleaned of irritating substances stops the peristalsis. As a rule the bowels are inactive during the first twenty-four hours. At the end of that period gas can be obtained by the aid of the enema and fecal matter will make its appearance within thirty-six to forty-eight hours from the time of the operation. Again, the apparent inactivity of the bowels is partially due to the wounding of the abdominal walls, thus lessening the expulsive force, making it necessary to resort to an enema.

I may be pardoned for saying a few words in reference to the use of the enema. If properly given it is a great aid, but improperly given may do untold harm. A fountain syringe should always be used. If soap is added to the water it should not be too alkali, the white soaps being preferable, otherwise a colic which may last several hours may be produced. An enema should not be used if the intestine has been wounded during the operation. An exception to this may be when the wound in intestine is high up—when a small salts and glycerine enema may be used with caution. The temperature should not be lower than that of the body and too much force must be avoided. In some cases a soft rubber tube may be used, thus introducing the water higher in the colon. In this case the water should be allowed to flow as the tube is being inserted.

Nausea and vomiting are also difficult symptoms to relieve. It is important to watch the character of the vomitus, especially so in abdominal cases, when there is danger of septic peritonitis or obstruction of the bowels. The normal vomitus may vary from a light mucus to a mixture of mucus and bile, sometimes of a greenish or even brownish color. The so-called septic vomit does

not, as a rule, appear until after twenty-four hours, unless the case be septic at time of operation. The first change will be in the color changing to a dark brown or black; there will also be small black specks floating in the fluid. The odor changes from the sour to fecal. These become more pronounced as the trouble increases and the vomitus instead of being thrown out from the mouth runs out without force. The rapidity with which sepsis runs its course makes it imperative that the first signs should be thoroughly appreciated; while it is always a grave condition, it is not always hopeless. Quick and active cathartics in the form of Epsom or Rochelle salts should be employed, followed by free use of stimulants, preferably in the shape of whisky.

During the first twenty-four hours remedies seem to be of little avail in controlling vomiting. Absolute rest of both body and stomach, giving nature a chance to reassert itself, seems to be the best treatment. If the vomiting persists then our remedies may be of use, especially those directed toward the nervous element.

The question of nourishment is one of importance. As soon as the stomach will tolerate water we should begin the administration of food. The nature and condition of the patient must be considered. A well nourished, strong subject will get along nicely two or three days on very little food; on the other hand, a weak, debilitated constitution requires help as soon as possible. The diet selected must be easily digested, at the same time highly nutritious. For the first three or four days liquid food, consisting of broth and milk with plenty of water, should suffice. The lighter the diet the oftener it must be given, starting with one drachm every hour it may be increased little by little until four or six ounces may be given at one time every two hours; unless very weak the patient should not be awakened for food. A weak lemonade is often agreeable to the taste and helps to right the stomach after the nausea of an anæsthetic. To this may be added the white of an egg, thus making it nutritious, Egg-nogs form an important addition to the broth and milk. When we wish to get the effect of a stimulant two to four drachms of whisky may be added to the egg-nog.

After four or five days, except in cases to be noted later, we may add some solid food, custards, jellies, toast dry or moist. The cereals, especially rice, eggs cooked in the various ways, with now and then a piece of tender meat. This diet should be sufficient for any patient confined to bed. There is a class of cases in which extreme care must be exercised. I refer to those in which the alimentary canal has been wounded by accident or in course of operation. In these cases any food which will form a mass must be kept away until the wound has had ample time to become firmly united. In these cases champagne is of value, followed by meat juice, broth and malted milk. From ten days to two weeks should elapse before any substantial food is given.

While it is important to nourish a patient after operation, it is equally important not to call upon the digestive organs to do too

much. A diet that appeals to the appetite both in nature and appearance aids in the convalescence. It is also true that the previous habit of the person must be taken into account. A hearty workingman will require different food from the person who picks out this or that nicknack. Meat and potatoes may be added to the former patient's diet sooner than to the latter.

I have said little as regards medication in these cases and I might add the less used the sooner mended. It is a custom with some to give as a routine, as soon as the stomach will retain it, a few doses of aconite. It is claimed that this acts as a preventive of fever. Certainly cases do well with its use; the same may be said of bryonia.

Upon the use of morphine many differ. As a rule, I believe it should not be given. There will arise cases in whom the nervous symptoms are so severe or the pain is so intense that it would seem best to secure rest with the hypodermic use of morphine, but in all abdominal cases where it is of the utmost importance to have free action of the bowels, it should not be used. It will mislead in the correct understanding of the condition of the patient. Of the coal-tar products which have come into such general use the last few years the same can be said as of morphine, although they act more as heart depressors than the former. I question if any case is improved by their use. The use of sugar of milk, with proper mental suggestions, as a sleeping powder may smack of quackery, but its efficacy can not be denied by those who have watched its magical effect.

It may be necessary at times to resort to laxatives to relieve the bowels, but this is more a mechanical than a pathological condition oftentimes relieved by the enema.

Certain symptoms may arise which will call for medication and each case must be treated by itself. Rest assured that the quickest recovery will come from the prescription closest to the Law of Similars.

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## DISCUSSION.

DR. COLLINS: *Mr. Chairman,* since hearing Dr. Roberts' first paper, about a year ago, I have adopted his manner of preparation of patients almost exclusively. I had noticed previously to hearing his paper that cases of appendicitis that were operated on without having time to empty the bowel except by an enema, did possibly better than where we had a long time to treat the patient beforehand, by emptying the bowel and so on. They had less trouble in starting the bowels after operation, say, on the second or third day. So for the last year I cannot remember but one or two instances where an active cathartic has been given before an operation, and that was in a case where the nurse had forgotten that my rule was not to give a cathartic. I must say that I am gratified with

the results. The patient, I think, has much less distension afterward, and requires, as I say, much smaller doses of medicine to open the bowels, where medicine is used, and a good many less enemata to start the gas, than with the previous method of treatment. Of course, if you have a week or two for preparing the patient, where the bowels are sluggish, a brisk cathartic four or five days before the operation, I do not think is objectionable, but I can heartily recommend Dr. Roberts' method of preparing patients, and have had better results since using it than under the old method.

DR. CLARK: *Mr. Chairman,* the essayist has made especial mention of an enema and the mode of using it. Now, I believe that the mode of administration is put down in all the text books. The instructions to nurses are to put the patient on the left side. That makes the colon more tortuous and more difficult to get the vehicle, or whatever enema is used, into the bowel. The patient, in my judgment, should be put upon the right side, which straightens out the gut and allows the fluid to flow in much more easily, and in my experience has been much more efficacious. The best thing for an enema after rectal operations, and after abdominal operations, in my opinion, is a flaxseed tea. It is very soothing and very efficacious; about a teacupful, or two-thirds full, of flaxseed, boiled in a rag, in about a quart of water for about twenty minutes, used as an enema, after it has cooled enough for such purpose.

There is one point, in regard to nausea and vomiting, that the doctor speaks of, that medicine does not always relieve, and that is caused by the congestion of the kidney from the effect of the anæsthetic, and I would like to emphasize two remedies that are particularly useful in that condition. They are carbonate of ammonia and mercurius coriceba.

DR. ROBERTS: *Mr. Chairman, Ladies and Gentlemen,* I just wish to say a few words, because this subject deals with a former paper of mine to a certain extent. I think that the question is still under investigation, of the use of a cathartic previous to operation. I have never taken the position of having drawn a positive conclusion from it, but my experience in omitting the cathartic, for a little over a year, has been very favorable. I have kept careful record of my cases, and I think I can see, and can demonstrate, from these cases as they have come up, that those which have not had the cathartic previous to a major operation have had a rather better recovery. I don't think that it is a matter of the highest importance, but I do think it is one of the small elements which go to make the convalescence of the patient more rapid and painless. A brisk catharsis is followed by a reactionary paresis. It is a matter of common knowledge with general practitioners particularly that a cathartic is followed by constipation, and this succeeding constipation comes on in our operative cases just at a time when constipation is least to be desired. I, therefore, believe still in omitting the cathartic.

# WEAK FOOT—ITS CAUSE AND TREATMENT.

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At a recent medical meeting I read a paper on the Treatment of Deformities of the Feet and Legs without the Use of Braces. During the discussion on that paper a good deal of interest was shown in regard to the cause and treatment of flat or weak foot. At that time I made the statement that all cases of flat foot are really cases of talipes valgus in some degree. This statement I shall take as the theme of this paper, and will add to it that the proper treatment of flat foot depends upon a recognition of this fact.

The weight of the body is conveyed to the foot through the tibia, which rests on the astragalus, and this, in turn, on the os calcis, Now this calcaneo-astragaloid articulation is of interesting importance. In the middle of the superior surface of the os calcis are two articular facets. Of the two, the external is the larger, and is situated on the body of the bone; the internal articular surface is supported on a projecting process of bone, called the lesser process of the calcaneum (sustentaculum tali). The inferior surface of the astragalus has articular facets that correspond with those on the os calcis. The ligamentary attachments between these two bones are the external calcaneo-astragaloid, the posterior calcaneo-astragaloid, and the interosseous. This last is the strongest of the three, and is situated in the groove that separates the two articular facets on the corresponding surfaces of the two bones. There is no internal ligament, its place being supplied by the superficial fibres of the internal lateral or deltoid ligament, the middle fibres of this ligament passing from the apex of the inner malleolus to the os calcis. The contact point between the heel and the floor is the internal tubercle on the inferior surface. As a part of weight of the body is transmitted to the sustentaculum tali, which is internal to the contact point, it would seem to be obvious that the top of the os calcis must rotate inward unless there is some support provided for the sustentaculum. This support is provided by the tendons of the flexor longus digitorum and flexor longus pollicis muscles coming from the calf of the leg to reach the bottom of the foot and passing in their course under the sustentaculum. Of course, if the os calcis were to rotate inward under the weight transmitted by the tibia, the astragalus would tend to be displaced, slipping off the top of the os calcis to the inside. As a check against such a displacement of the astragalus we have the tendon of the tibialus posticus that passes across the internal lateran ligament and beneath the astragalo-scaphoid articulation to reach the sole of the foot.

The bones in the sole of the foot have an arched arrangement. It is generally taught and believed that the arch of the foot is intended as a spring, that whenever the weight of the body is suddenly added to in supporting some heavy object, or the natural weight of the body is suddenly thrust upon the foot as in jumping, the arch will straighten and the foot become flatter as it goes down with the weight. It is further believed that flat foot is a permanent flattening of the arch. Now there are three elements that contribute to the maintenance of the arch of the foot. First, there are the ligaments that serve to maintain the relative positions of the bones. The most important of these ligaments is the long calcaneo-cuboid; it is attached to the under surface of the os calcis, from near the tuberosities, as far forward as the anterior tubercle; its fibres pass forward to be attached to the ridge on the under surface of the cuboid bone, the more superficial fibres being continued onward to the bases of the second, third and fourth metatarsal bones. You will notice that this ligament lies wholly under the outer half of the foot, where there is very little arch at any time. The most markedly arched part of the foot is the inner half where there are only short ligaments that bridge across and hold together contiguous surfaces of the tarsal bones. The arch cannot flatten, therefore, under sudden weight without a stretching of these ligaments. Now ligaments are not elastic structures. Gray, upon whose descriptions I rely for all the anatomical facts in this paper, says: "Ligament is pliant and flexible, so as to allow of the most perfect freedom of movement, but strong, tough, and *inextensile, so as not readily to yield under the most severely applied force*" (the italics are mine). He further says: "Some ligaments consist entirely of yellow elastic tissue, as the ligamenta sub-flava, which connect together the adjacent arches of the vertebræ, and the ligamentum nuchæ in the lower animals. In these cases, it will be observed that *the elasticity of the ligament is intended to act as a substitute for muscular power.*" I call your particular attention to the part of this latter quotation that is in italics, as it bears out exactly a proposition I shall submit presently. The ligaments cannot, therefore, stretch and allow the foot to go down under sudden weight. It is true they may become weakened and give way under long continued strain; it will, however, be a permanent weakening.

The second factor in maintaining the arch of the foot is the plantar fascia that runs from the os calcis to the distal ends of the metatarsal bones. Now, aponeurotic or deep fascia, such as the plantar ligament, "is a dense, inelastic, unyielding fibrous membrane." Whatever alteration in the tension of such a fascia may occur, it comes about by muscular action.

The third element in maintaining the arch of the foot are the muscles attached to the arch of the foot, the tibialis posticus, the flexor brevis digitorum, and the flexor accessorius; and the tendons of the flexor longus digitorum and flexor longus pollicis that pass under the arch of the foot to their insertions. The part played by these muscles is to sustain the arch of the foot, to keep it from

falling inward toward the ground through the weight resting upon it.

The arch of the foot is like a bridge; it is built for strength and not for elasticity. Muscles are the only elastic structures of the body that control the position of bones. Whenever there is any unusual force exerted, we find some provision for the distribution of that force. When a jumper lands, every joint in the lower extremity is flexed, and every muscle of that extremity receives that weight. As the tibia receives the weight of the body, and rests upon the inner half of the foot, it pushes down the inner side of the foot, and as the only support of that side of the foot is the tendons that pass down the inner malleolus and behind and beside the astragalus and under the sustentaculum tali, which above form the deep muscles of the calf of the leg, the strain comes upon these muscles of the leg. This action of the foot, under severe strain, often produces Pott's fracture; the force, crowding the inner part of the foot downward, carries the outer part of the foot upward and outward against the fibula, breaking it off where it curves toward the tibia about four inches above the ankle joint. To avoid this accident, the toes and the metatarsal bones are flexed, and by the direction of the flexor longus digitorum muscle, they are drawn inward, so that the weight of the body is gradually lowered as the back part of the foot settles to the ground and the top rolls inward with the increasing weight.

If the bottom of the wet foot is placed upon a polished floor it will leave an impression, not of a broad, flat surface, but of several points of contact, one for the heel, one for the base of the great toe, and others for the bases and tips of the outer toes; and the outer margin of the foot will also touch. If a number of people leave their foot impressions on the floor, we should find that they differ much in design. The contact points for the heel and great toe would be found in all cases, showing that the weight of the body is always received on these two points. As the toes are always turned slightly outward in walking, a line drawn from the heel to the great toe is parallel to the line of progress; and the weight of the body is supported on these two points, just as the weight of the rider is supported by the two wheels of a bicycle. When standing on one foot, our energies are devoted to keeping ourselves from falling inward or outward; in walking slowly, when a measureable length of time is spent on each foot separately, we notice the same disposition to tip inward or outward; but the faster we go the more easily we maintain the upright position, as in riding a bicycle. The number and size of the other contact points made by the foot vary with the amount and location of the superimposed weight; but they are always to the outside of the heel and great toe line, while the weight of the body through the tibia that receives it, falls to the inside of that line. We have, then, a kind of rocker effect in the foot; the weight of the body conducted through the tibia pushes the inside of the foot downward; when the weight is relieved, the inside of the foot rises. This rocking motion is at right angles to the heel and great toe line, which actually serves as an axis for it; and it is

controlled entirely by the deep muscles of the calf of the leg which pass behind the inner malleolus to the inside and bottom of the foot.

Now it is evident that if the inside of the foot is to maintain its normal position in spite of the downward pressure of the tibia, the muscles that hold that side up must remain of normal tone. If the tone of those muscles be impaired, the equilibrium between the weight and the support will be broken, and the top of the foot will rotate inwards, that is, the inner boundary of the arch of the foot will descend until it is nearer or touches the floor, according to the supporting power of the muscles. If this descent is of slight degree, the deformity is called flat foot; when the deformity is quite marked, as in paralysis or extreme weakness of the deep muscles of the calf of the leg, it is called talipes valgus. That is what I started with—flat foot and talipes valgus are different degrees of the same condition.

If flat foot is due to a rotation downward due to the weakness of the muscles passing under the sustentaculum tali, as I claim, two other irregularities of the position of the foot as a whole will be noticed; in the first place, as the inside of the arch of the foot goes down, the outside must rise; and in the second place, if the sustentaculum tali drops through lack of support, the upper surface of the os calcis must slope inward, and there will be a tendency for the astragalus that rests upon that upper surface to slide off downward and inward so that it can be felt unduly prominent on the inside of the foot.

If you will examine your cases of flat foot you will find, I think, that both of these irregularities show themselves. If flat foot is due simply to a stretching of the plantar ligament, as I believe is usually claimed, there will not be this raising of the external border of the foot or the lateral displacement of the astragalus. In illustration of this point I present three illustrations. Figure 1 represents an impression made by the wet sole of a weak foot on a firm surface. This impression was made when but little of the weight of the body rested on this foot. The second impression shows the result of putting the full weight of the body upon the same foot. The third shows the outline of the foot, under the same circumstances as in figure 2, drawn by a lead pencil. In figure 1 we see the normal contour of the outer border of the foot. At the point A we have the junction of the os calcis and the cuboid. In figure 2 there is quite a change in the outer border of the impression, an appreciable concavity occurring at the point A, due to an elevation of the outer border of the foot as it rolls inward under the increasing weight, making a part of the sole further under the foot give the extreme outer border of the impression. On the inner side of the impression we have a marked convexity at the point opposite A. This is due to the soft parts that lie under the head of the astragalus coming in contact with the floor as the bone descends. If flat foot were due to relaxed ligaments on the bottom of the foot, there would be an increased convexity in the impression of the outer border of the foot instead

of a concavity. In figure 3 there is a greater convexity on the inner border of the foot due to the fact that the pencil passes the inner border of the head of the astragalus and the scaphoid, which project beyond and overhang the soft parts that make the impression in figure 2.

The proper treatment of weak foot must be based upon a recognition of the anatomical principles involved in its production. At the present time considerable interest is shown in some form of metallic insole arched in such a way as to support the bottom of the foot, thus attempting to restore the arch of the foot. In most instances the arch of the instrument is exaggerated, producing pressure upon the muscles in the sole of the foot with consequent weakness and absorption. An exaggerated arch, too, causes direct pressure upon a surface of quite limited area which is in many cases intolerable. Another objection to these supports is that they are liable to move about in the bottom of the shoe and get out of position. In planning a support we must arrange to furnish that support at the point where nature fails to supply it. I have endeavored to show that the deformity called flat foot is primarily due to a descent of the sustentaculum tali owing to a lack of muscular support of the weight of the body resting upon it. Our artificial support must, therefore, be planned to hold up the sustentaculum tali and prevent the inward rotation of the top of the os calcis. And inasmuch as the drooping of the sustentaculum allows the astragalus to slide off the upper surface of the os calcis and become unduly prominent on the inside of the heel, the apparatus should be arranged to hold the astragalus in its normal position and prevent its inward dislocation. If my theory is correct the deformity is at the back part and inner side of the foot, and the support in ordinary use exerts its pressure much too far forward.

In the treatment of weak foot, then, we must restore the foot to its normal position and keep it there. If the abnormal position is due to inward rotation of the top of the os calcis and descent of the astragalus, which is situated at the back part of the foot, and as this descent drags upon the muscles whose tendons pass under the astragalus, thus reducing their vitality still more, the indications are to elevate the back part and inside of the foot and push the astragalus back into its normal position, so that the strain upon the muscles will be removed and they can, by exercise at their normal length and in their normal position regain their normal tone.

Much can be done in these cases by adapting the shoe to prevent it from turning with the foot, and elevating the heel to rest the muscles.

I take the position that a brace is an unnecessary, injurious, and unjustifiable appliance. That it cannot accomplish anything that cannot be accomplished with a shoe. And that it immediately takes the place of the muscles of the leg, produces undue pressure upon those muscles and the blood-vessels, all of which produces atrophy. As the muscles control the foot the loss of the muscles allows increase of deformity.

# WHERE THE DISCREPANCY?

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It is not a pleasant reflection, but one full of truth that the medical fraternity, as a class, occupy an inferior position as compared with other professions of the day. It lacks the prestige it deserves in proportion to the benefits rendered.

In evidence of this I refer to the fact that of all the names suggested for the Hall of Fame there was not one doctor in the number. Yet what greater service has been rendered humanity or what more heroic deeds have been done than those performed by medical men when one after another of the most feared divisions of the hosts of pestilential germs have been put to flight or exterminated? Who drove the plague back to its jungles—stamped out cholera, overcame the dread effects of small-pox, and forced the yellow fever from our Southern shores? Who was it but the doctor who reduced to the minimum the dangers of tuberculosis, scarlet fever and diphtheria? What noted warrior has served humanity a greater purpose, what statesman ever afforded a more lasting benefit, what artist ever produced a more worthy subject, what inventor or invention ever did more for the people of the earth? Thus we might compare every vocation in life and we would still find remaining the balance of testimony in the doctor's favor.

With all this the doctor is constantly discriminated against. The law demands of him that he shall spend from four to six years of the best part of his life at hard study. This entails not only a loss of valuable time, but also a large expenditure of means and when he is through he finds himself on a par with the commonest street vender of pills and proprietary prescriptions, whose only recommendation is the song and cry of the negro minstrel who tries to popularize them, the flaring circular that so applaudingly introduces them or the newspaper cut and testimonial of some ex-city or national politician who seeks to advance them.

The doctor bears the stamp of inequality. His liabilities are both criminal and civil. The laws are full of menace to his savings and yet he must compete with every uneducated quack. He is expected to guard the public interests by inventing means of preventing disease and it is necessary that he withstand the personal danger of every epidemic and contagion, no matter how great the risk. Still he is liable to be supplanted by the influence of the commonest town gossip, and not infrequently when doing his duty honestly and earnestly, he becomes the subject of public ridicule.

This being the situation (and we all know the picture is not overdrawn) it surely is not out of place to ask where the discrepancy,

and to consider the remedy. A reasonable response to this interrogation will doubtless throw some light on this perplexing problem. It is the object of this paper to create free discussion of the subject, to awaken latent interest, develop renewed force and indicate some plan whereby the present condition of things may be equalized.

To accomplish this purpose it is necessary to deal with the question unreservedly. It will not do to mince matters. Facts must be considered, principles faced and policies invented. Times have changed, systems have been altered in every vocation of life. Every avenue of trade, every source of commerce, every governmental interest is crowded with individuals for the promotion of their own and the general welfare. Everywhere is present a disposition for the advancement of standard, increase of prestige and the promotion of the common good and from almost any of the business interests of to-day may be taken object lessons of no little value to our profession.

There are few vocations but have been awakened to the necessity of the times, but the doctor still trudges along in the same old way, without business tact or individual acumen. Try as he may by legislation, personal influence, or organized force, he still finds the records of the present repeating the history of the past.

In looking for the causes of this lamentable situation let us consider them in proportion to their importance. At first thought it might seem that the laity alone were to blame, but a careful study of the details shows that some of the greatest obstacles to professional advancement lie within the fraternity. The constant disagreement and bickerings among doctors themselves are the occasion of much belittlement. The general disposition to decry each other, to ridicule each other's schools and to take exceptions to each other's plans of treatment, constitute within themselves the greatest source of injury.

Couple this, if you please, with the uneducated kind of material, of which too many of our doctors are made and we at once become possessed of the key to the situation. To overcome these difficulties it becomes necessary to begin with the student. No doctor, or college should admit as students of medicine other than educated men and women. The acquisition of a thorough and practical literary education is within the reach of every one and nothing short of thorough education should admit any one to the study of medicine.

With the numerous institutions of learning the country affords, medical students should have a college education. At least there is no reason why the medical student should not have an academy degree. The requirements of medical education have been increased entirely out of proportion to the preparatory education. The superstructure that is contemplated in the present system of medical education is too great for the foundation upon which it rests, therefore, the first duty in this matter lies with the doctor who either admits or recommends an unqualified medical student, and the first step in the process by which the end sought is to be obtained, begins here. If

better judgment is employed in the selection of raw material we will have much less trouble in establishing for the medical fraternity the prestige and position to which it is entitled, because we will have created a respectful and educated body.

Nothing so detracts from professional position as does ignorance of its constituents; nothing adds as much dignity and force as does trained intelligence. The policies of our medical colleges must be changed. Too many of these still think that it is necessary to verse their students in antiquated precepts, to teach them restricting dogmas and to school them in fossilized creeds. These are the conditions which occasion so much of the differences that exist between doctors themselves. They have been taught by their Alma Mater to decry every one else and everything else save he who, like himself, has been ground out of some special mill, and so long as such methods prevail, we can not expect other than discredit and disrespect from the laity.

Here arises from the very start the mark that taboos the doctor and discredits his service, and until there is a broader basis upon which physicians are created and operate, until broader lines and wider observations have attained the ascendancy, the medical profession will still remain the subject of ignominious treatment.

This brings us to the consideration of questions difficult of solution, because it necessitates the origination of new plans and policies, some of which being such a diversion from the old line, will doubtless bring criticism, but as it is our purpose to excite discussion, we assume the responsibility.

The doctor of to-day is not like the doctor of two decades ago any more than the commercial interests of the present are like those of our Puritan fathers. Twenty years ago a knowledge of Materia Medica and a few primitive surgical principles were the only requirements. The doctor of even so short a time ago was not particularly interested in the prevention of disease. He received no encouragement for the doing of things that kept people from getting sick. To-day all is different. Bacteriological research and sanitary science; hygiene and scientific dietary; physical culture and psychical influences are claiming the attention of the medical profession to a degree never before known.

Up to the present time the medical fraternity has been engaged almost entirely with the physical causes of disease. It has learned the origin of typhoid fever, of malaria, of consumption, of diphtheria, of scarlet fever, of measles and numerous other conditions that menace the welfare of humanity. But with all this accumulation of knowledge, the doctor still finds himself in disrepute with many who should be his supporters, because he has not developed means which affect the psychical side of the human being. He has become perfectly familiar with organic changes and their phenomena, but so far he has left to the charlatan the development of the means to be used in dealing with functional disturbances and psychical manifestations. His investigation along the line of general health

improvement by anticipating disease has been the wonder of the age. His invention of surgical methods and surgical procedure have demonstrated how earnestly and how certainly he has been progressing, but with all this, he has failed to incorporate with other means forces which touch the psychical side of life and in so doing has failed in one of the great purposes of the profession, thereby laying the whole fraternity open to criticism and the development of side issues which have worked harm.

Thus have originated the various side shows that have detracted so materially from the power and usefulness of the medical profession. People who are sick want to get well no matter from what source, and to meet all the demands, the modern doctor's resources must be unlimited. He must not only know how to detect the cause of disease, to differentiate between real and imaginative ones, but he must also know how to prescribe whatever in physical or psychical forces of any kind may be indicated.

Up to the present the profession have contented themselves with disparaging and speaking lightly of the various methods of would-be-cure-alls and with this has ended the opposition to impostors, and the general public has been allowed to go on employing methods which were hurtful to the medical profession and in many instances injurious to themselves. The real way to overcome the influence and effects of these limited and one-sided forms of treatment is to educate people as to their real worth. It is not enough to simply belittle the principles of Christian science, to ridicule osteopathy, to throw mud at hypnotic influence, to decry suggestive therapeutics, or laugh at Dowieism. The means to be used against these over-estimated forces should be such as to demonstrate such merit as they possess and to show without doubt the misrepresentation they make.

The doctor must be broad enough in his policies of education to meet all the demands of his client, whether his trouble be an organic and physical one, or an imaginative and psychical one, and it is the duty of the medical colleges of the times to institute educational policies broad enough to meet these demands. It is the duty of doctors, as an organized class, to look thoroughly into the merits and demerits of any promulgated plan, system or measure of cure suggested by any one, no matter what the source, and determine its real field of usefulness and once having settled the question with fairness, it should be the duty of organized medical bodies to insist upon the recognition of its justice or injustice. If it is good, to use it for good and incorporate it as a medical requirement; if bad, to condemn it as bad and leave nothing undone to punish the offender, but in any event to teach the laity that it is only a link in the chain, not the chain itself; a unit and not the whole, and as such is only capable of a part.

To meet all the demands of the day from a medical standpoint, therefore, means more than to be versed in Materia Medica, educated in surgical science or practical therapeutical application. It means

more than to consider the human body from a physical standpoint alone. It means a better understanding of the relation between psychical mianfestations and physical effects. It means that every doctor should stand shoulder to shoulder with his colleague, determined to help and elevate him. It means that he shall be an educator and in order that he may be capable of giving instructions that he be thoroughly educated himself.

The only recourse the medical fraternity has by which it may elevate its standard and beget the credit and respect to which it is entitled, is by organized effort on the part of the profession to increase the demands of eligibility to the profession and improve the methods by which the laymen may be educated to a full and complete knowledge of what constitutes a real doctor. To obtain the position we seek, it is incumbent upon us that we use every possible influence to raise the standard of the profession. It may seem like a herculean task and one almost impossible of accomplishment to so completely revolutionize matters as to obtain the object sought, but persistent effort will ultimately merit its reward.

As a means of bringing about the desideratum, I would suggest that every medical association, local, state or national, take some steps whereby the real truth regarding various questions of importance be taken up with the laity as well as the practitioner.

One of the greatest shortcomings of the every-day medical literature, is the fact that it does not reach enough of the laity. Doctors should write more for laymen and medical literature should be more fully circulated. Who can conceive of the influence of the reprints of the "Message to Garcia", as distributed by George H. Daniels, President of the New York Central Railroad. The purpose it has served for good is incalcuable. The American public is most eager for instructions along any line and especially along any line which interests their personal welfare. I firmly believe that any and all of the medical journals of the country could vastly increase their subscription lists and materially improve their influence for good if they would adopt a layman department and seek lay subscription. This department could be well used for the consideration of general subjects.

Nothing has so changed the mortality rate and health statistics as the cleaning up of filthy habitations; nothing so purifies the cess pool as the fresh air of Heaven and the penetrating sunbeam. Nothing would help more to overcome the vile influence of pretense and pretenders than the light of education.

To do our whole duty we must first clean our own professional hull of its barnacles; we must widen our observation lens; we must open wide the professional shutters and let the sunlight of education penetrate the darkest recesses; we must desist magnifying and advertising our professional difficulties; we must become instructors of the general public as well as general practitioners; we must learn to respect the thinker and the thoughtful, the inventor and invention, and whether principles devolved or means suggested are in

strict accord with our former views and experience, we must investigate them without malice. We must necessarily be charitable toward our colleagues. It must be our constant desire and determination to build up the reputation of the profession. To accomplish this we must discourage in every way possible unkind sayings or actions of our professional brethren, and we must improve every possible avenue of respectful consideration.

A deplorable condition exists in many of our cities which are the seat of medical colleges. Our representative men are found knifing each other on every occasion. How many of our college cities are in a condition of constant professional disruption because of petty jealousies, personal animosities and individual foibles? How can we expect the young practitioner to be full of a feeling of brotherly love when he finds his professors always at the outs with his colleagues. Men who are so narrow as to wish to usurp everything for themselves are entirely too narrow to be useful to the profession and each professional man should be taught this as a part of his training.

The day must surely come when the real doctor will be recognized as a most needful force in every community and when the laity have become educated as they should as to what constitutes a real doctor, there will no longer be any question as to the position the medical fraternity will occupy or the force it will sway.

Look if you will upon the advancement along the lines of education in our public schools, relative to the public health and I feel sure that you will recognize in the handwriting on the wall the coming of the day that the appellation "doctor" will stand for much more than it now represents. The near future has undoubtedly in store much of benefit to the medical profession. Glancing backward we note that the policies adopted by the present national medical bodies are broader in their admissions, stronger in their relations and more generous in their disposition than ever before.

Slowly but surely we are approaching a general amalgamation of forces which will be to the glorification of all. There has been a general unbending on the part of the old school. Doors that heretofore have been locked against others than those who subscribed to a particular creed are now being opened and the signs of the times indicate that the day is not far distant when doctors will be recognized by their ability to do good. By their understanding of all matters pertaining to the health and welfare of the public. By their being men of letters. By their ability to cope scientifically with all problems of importance to the health and therefore the greatest welfare of the people. By their forgiving and generous disposition to brothers of the profession. By their earnestness of purpose in stamping out practices that are injurious and by inculcating such as are beneficial.

## DISCUSSION.

PRESIDENT GREENLEAF: The very enthusiastic reception of this paper makes me ask your permission to thank the distinguished gentleman for the paper, and particularly for the spirit of it and its breadth; and it seems to me that all that is therein contained was epitomized away, away back in the history of the race when there was one great Physician who went about doing good, and who from His standing spoke "with authority and not as the scribes."

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# REPORT

OF THE

## BUREAU OF GYNÆCOLOGY.

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"Sterility and Fecundity," - - - - DEWITT G. WILCOX.
"A Report of Some Clinical Cases," - - - M. BELLE BROWN.
"Sexual Neurasthenia," - - - - - A. R. GRANT.

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## STERILITY AND FECUNDITY.

DEWITT G. WILCOX, M. D.,
BUFFALO.

While much has been written of late, relative to the increasing sterility of American women, there is yet much to say; and were the same words which have been said, repeated at each medical gathering, the subject would not receive any more emphasis than it fully deserves. The Biblical injunction given the patriarchs of old, was explicit and forcible. "Be ye fruitful and multiply." The punishment for failure to obey the injunction was swift and direct. Sterility had no place among the Israelites.

President Roosevelt said recently, in one of his public speeches, that the "barren woman by choice and the idle man were of no use on earth."

It is of this "barren woman by choice" that I wish particularly to speak, although I shall have a few words concerning the pathologically barren woman. The increasing observance of the "fashion" not to have children, seems to find its chief devotees among American women. Although the increasing sterility is more marked amongst them, yet in England the subject is receiving much attention from

medical men, because of the serious decline in the English birth-rate. In an editorial of the British Medical Journal of recent date, appears the following: "In the year 1875, the birth-rate in the United Kingdom was 35 per 1,000 of the population, in 1900 it was only 29. This means for our population of 41,500,000, a deficiency of 249,000 children for each year, or 6,225,000 for the twenty-five years, and implies, as pointed out by Dean Fremantle, a much more rapid decline of the birth-rate than in France, in which the process has been a slower one and longer established than in this country."

In an article in the British Medical Journal of June 22nd, are these words: "The net result on natural increase produced by the lowered birth-rate and death-rate was shown; and it was made clear that the lowering of the death-rate is not keeping pace with that of the birth-rate, and that in the future, as the average of the population increases *pari passu* with lowering of the birth-rate, the balance of increase of population is likely to become less. The lowering of the birth-rate and the resulting lowered rate of natural increase of the population have been concealed by the greater amount of immigration in recent years, and by the lowered death-rate, by means of which we have saved about half the loss due to the lowered birth-rate."

Turning to American statistics we find these startling facts, gathered by that authoritative statistician, Dr. George J. Engelmann, of Boston, and presented before the late meeting of the American Medical Association, held in St. Paul. He says: "Long accustomed as we, as a nation, have been to consider ourselves a fruitful and progressive people, in marked contrast with some of the races of Southern Europe, notably the French, we are the least fruitful people of the world. As clearly portrayed by figures that it will admit of no controversy, to-day the American born people show a fecundity of less than two children per marriage. That is to say, there are barely two children born to a family among those who can claim to be native white Americans. One hundred and more years ago, during the colonial period, the fecundity stood at six per marriage, while to-day the general European fecundity is 4.5 per marriage, but the French Canadians show the enviable record of 9.1 per marriage. Closely associated with the foregoing statement is the occurrence in Europe of one miscarriage to every 3.3 labors, while in this country a premature expulsion of the ovum occurs in 2.8 labors."

"The percentage of sterility in the United States is higher now than that reported in any other country; the percentage of miscarriage and divorce is likewise higher, while that of fecundity is lower than in any other country. In the one century that has passed, the position of the American women, as regards the reproductive function, has been relegated from that of pre-eminence to one inferior to that of women of all other countries. Sterility, one hundred years ago, the least, is now the greatest, and this with miscarriage, has increased as gynæcological science has progressed."

Now as to the cause of this markedly increasing sterility. The editor of the British Medical Journal says: "The general cause of

the serious decline in the birth-rate is not difficult to discover. It is correctly attributed 'to the wish for ease and material enjoyment.' That it is some general cause and not circumstances impending the sub-division of properties to which it has been attributed in France, is shown by the international character of the reduction of the birth-rate. Some further light is thrown on the means by which large families are prevented, by the fact that the reduction in the birth-rate has been much greater in Protestant than in Roman Catholic countries. France appears to be an exception to this rule; but that country is largely materialistic, and it is doubtful if Roman Catholic teaching on this subject dominates the population. The reason why Roman Catholic population show a much smaller decline of the birth-rate than Protestant population, is that among the former the production of abortion and the prevention of conception are alike regarded as deadly sins, the continuance of which prevent absolution from being obtained. That there is no essential physical reason for the decline in the birth-rate in France is shown by the enormous birth-rate of the French Canadians, who remain orthodox as well as prolific. The fact cannot be disguised that the chief means by which the great lowering of the birth-rate in most civilized countries has been brought about, has been by the dissemination of instruction as to the means of artificially preventing conception. The medical profession, as a whole, has set its face against such practices, which are unnatural and degrading in their mental effect, and at times, injurious to both husband and wife in their physical results. A small number of medical men have held and taught other views, but the evil has been chiefly caused by cheap pamphlets on the subject, and by advertisements in weekly and other newspapers (often so-called religious newspapers) which, under a very thin disguise offer facilities for procuring abortion or preventing conception. Dean Fremantle's letter gives us some hope that the voice of the clergy may be heard more clearly in protest against such practices and that the public conscience may be aroused to secure an abatement of what is a great national danger. The prevention of conception is doubtless the chief cause of the lowered birth-rate. More attention, needs, however, to be given to the production of abortion, which, it is to be feared, is more prevalent than is commonly imagined."

Under the head of causes of voluntary sterility (if I may use that term) are to be considered, prevention of conception, early abortions and sexual abstinence. According to the quotation just read from the British Medical Journal, that editor regards the dissemination of instruction as to the means of artificially preventing conception as largely responsible for the lessened birth-rate and he further states that the evil has been chiefly caused by cheap pamphlets on the subject and advertisements in weekly and other newspapers, which advertise to produce abortions under the thin guise of monthly regulators.

I am thoroughly in accord with this position and it is high time that the medical profession took this matter up and waged against it the warfare that its criminality deserves.

In an editorial of the Journal of the American Medical Association, there appear these words: "If the remedies are harmless and will not accomplish the results covertly claimed for them, then they are frauds and humbugs of the most villainous kind. On the other hand, if they are efficacious in the manner intended, then their sale and use is criminal and the newspaper that admits such advertisements is a participant in the crime. The editor can take whichever end of the horn he chooses; in advertising such remedies he is either selling his space to humbug people or is allowing the space to be used for criminal purposes. He cannot plead ignorance. When certain pills are advertised as 'monthly regulator, safe and sure; never fails;' and when the advertiser says, 'send for woman's safe-guard' there is no doubt as to what is meant. The editorial apology is pitifully weak, not to call it anything worse. 'Money talks' altogether too much with the advertising department of the daily press, and morality and even common decency must take a second place."

There appear in our best Buffalo papers to-day, papers which call themselves family papers and boast of their freedom of sensationalism and fraud, advertisements which mean nothing else save the prevention of conception and the induction of early abortions. In three of our daily papers there appears to-day an advertisement which states as plainly as words can be made to state a fact and yet not employ the actual word designating the act, a statement that Dr. Blank, of such a street and number will induce an abortion upon any woman who is despondent and in trouble. Within a dozen lines from that card is another one, advertising a compound for suppressed monthly periods. There can be no possible excuse on the part of the newspaper managers that they are ignorant of the meaning of these "ads." If they do not know what they mean, the manager should seek advice from reputable medical men and find out what they mean and if he wants to make himself absolutely sure of their meaning, let him send a decoy patient to the dens of these professional, would-be abortionists and learn beyond doubt that their work is criminal, and they, the newspapers, are parties to such criminality.

Ninety-nine per cent. of such advertisements are frauds, absolutely, for the reason that none but the most powerful drugs will induce sufficient uterine contraction to expell the fecundated ovum, and the average advertiser is afraid to place in the hands of a desperate woman so powerful a remedy. They depend for their reputation and gain upon the deluded victims who imagine themselves pregnant and who will, in time, menstruate without treatment of any kind. To the class of criminals who actually induce instrumental abortions, there should be meted out a swift punishment. Not alone to them, but to all who in any way contribute to their support, whether by advertising their methods or referring patients to them. They are the destroyers of the "yet unborn" in that they, not alone abort the progress of the fœtal growth, but in the majority of instances, set up an infective inflammation of the uterus and tubes, which renders

the victim both sterile and an invalid for years to come. I wish this body and other medical societies might adopt resolutions vigorously denouncing the laxity of newspaper morals in advertising methods and so-called remedies, whose aim and intent is the production of criminal abortions.

Passing to the subject of preventing conception, there is much to be said and I fear some censure is due the medical man for a dissemination of this knowledge. There appears at the present time no hesitancy whatsoever on the part of husband or wife in going to the family doctor, immediately after marriage, or in some instances, before, and telling him very plausibly that they are not in a situation to have children; that there are physical, financial or social reasons why they particularly should be exempt and that, as their medical advisor, he should inform them how to live together and escape the duty of having children. The physician who is induced or who voluntarily imparts such knowledge, when there is no good and sufficient physical reason for the parties to escape their rightful burden, not alone commits a moral wrong, but he is an enemy to his country and society at large.

In the discussion of Dr. Engelmann's paper, one of the physicians present said: "It is undoubtedly high time that we, as a people, should give this matter of fecundity and sterility careful attention, and still more, that we physicians, as the medical guardians of the nation's welfare, take such measures as will tend to suppress vice and encourage the propagation of the race." Dr. Duff's suggestion, which was unanimously indorsed by the meeting, that hereafter the United States Census take note of the paternity (parental nativity), sterility and fecundity of the people, is a most excellent one. The publication of such records would do much to open the eyes of the best element of the country to the danger that is impending. As to the willingness of individuals to assume the important responsibilities of maternity or paternity, this is a phase of the subject that can be influenced only by appealing to the morals of the people. As was suggested by one of the women delegates, an improvement in this direction might be instituted by substituting the questions: "Are you willing to become a mother?" "Are you willing to become a father?" at the time of issuing the marriage license. Failure to acquiesce, in her view, would be deemed ample reason to refuse the license on the ground that legal prostitution could not be countenanced.

The disinclination of the present generation of young married people to have children must be overcome by a rightful education and this must emanate from the family physician and the mother of the young wife. I am frequently surprised to find the mother of three, six or eight children cautioning her married daughter not to be in any hurry about having children and even attempting to instruct her how to avoid, what she calls, such a calamity. Their excuse, generally, is that there is time enough later in life. Just now they can't afford to have children, while the physician knows that the

majority of first children are born within the first fifteen months of married life and the woman who does not have her first child within fifteen months following her marriage, is quite likely to be childless, for two reasons: first, if no effort has been made to prevent pregnancy, there is something physically abnormal which precludes it, and that physical disability is likely to continue through sexual life. Second, if the woman has been successful in preventing pregnancy for that period of time, she seldom finds a time when it would suit her to have children and thus she lives until her fecundity is so lessened that she is childless the rest of her days.

The time allotted me is too brief to consider more than one of the causes of physical sterility, but that is the chief and most alarming cause, namely, gonorrhœal salpingitis. No one but the gynæcologist knows what an important part this disease plays in the production of the reduced birth-rate. The family practitioner is cognizant of it in a general way, but unless he sees, as can be seen in hospital practice, from one to six women every day, who are not only sterile, but who are miserable sufferers and semi-invalids with this pestilential disease, he can have but an inadequate idea of its prevalence and destructiveness.

Lamentable as it is to find such a number of victims of this disease, it is equally bad to learn that there is no cure for them so far as the sterility is concerned. Were it only the prostitutes and abandoned women who were its victims, we might not feel it such a calamity that they could not reproduce their kind, but when it seeks out the fairest women in our land and enfolds them in its coils before they have known the sweet dream of motherhood and while they are yet in the prime and vigor of sexual life, it shows not alone how deadly is its venom, but how widespread.

I indorse most heartily the proposed legislation in other States, that no man should be permitted to marry unless he can show himself absolutely free from all gonorrhœal taint as to preclude the possibility of infecting his intended wife. I wish we might agitate such legislation in our own State, for gonorrhœa is an enemy, whose destructiveness to the vitality and numerical strength of the state is as great in an indirect way as that of tuberculosis and fully as worthy of a great effort at its utter annihilation. (Applause.)

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## DISCUSSION.

DR. COLLINS: *Mr. Chairman*, the statistics given in this paper rather astonished me, especially in regard to our fair country. As to the ravages of gonorrhœa and abortions, I think that at least one-half, and perhaps two-thirds, of the cases of the gynæcologist come from those two causes. There is probably nothing equal to gonorrhœa and miscarriage for producing troubles with the appendages. I think that the doctor's idea of legislating against it and insisting upon

every man being examined before he is allowed to marry, would certainly be a great help in the line of preventing these diseases. If it is done it should be done in a scientific way. I think a microscopical examination should be instituted in every case; because I have often found that men coming to me to ask if they were in shape to get married, when examined in the day time would apparently be all right. There is no discharge in the day time, but if you examine them in the morning before they urinate, you will find sometimes a little discharge, or if they should drink a few glasses of beer it would bring on a discharge. I think the genito-urinary men insist upon the drinking of a few glasses of beer if they wish to make a thorough test as to whether the discharge from chronic gonorrhœa has any gonococci present or not. If we simply allow every practitioner to examine these men and give them a certificate that they are in condition to be married, I do not believe it will be of any great avail; but I think legislation in that direction would be very efficacious if it were gone about in the right way.

DR. TALCOTT: *Mr. Chairman,* I was very much interested in Dr. Wilcox's paper, and if his suggestions could be carried out, very profitable ends might be subserved. I think sometimes that the fears originated from some sexual lapse have a very severe effect upon the mental and physical structures of the human being. Young boys and young girls sometimes indulge in "home industries" to an unprofitable extent, and these produce very sad effects. Young men sometimes contract gonorrhœal diseases, and the worriment caused by such a disease has a lowering effect upon the vital energies, to such an extent sometimes, as to almost destroy sexual power afterward. I think that is one thing to be considered, and I think that the general teaching of the physician should be to encourage hopefulness on the part of the patient, in order to overcome by that mental means the tendency to severe and long-continued disorder. I do not think I can add very much to the value of Dr. Wilcox's paper, because he has made it so thorough, so searching, so graphic and so complete, that it is almost unwise for any of us to try to add to a piece of work which has been so carefully and thoroughly performed.

CHAIRMAN ROBERTS: If I may be permitted just a word,—it seems to me that the paper covers an important field, but still only a small part of another field, which is very much wider, and very much more important, namely the method of education of children. It seems to me that the reason we are not having more children, the reason so much effort is being made either to prevent conception or to bring on miscarriage, is the picture which stands before the public, which stands before us all, as to the highest attainment of life. The poorer class of people, the more ignorant people, look upon a large family as the crowning effort of a life's work. The more wealthy, educated class of people look upon the amassing of wealth and the enjoyment of luxury and ease as the highest attainment of life. Not only that, but we begin in early youth with our children by putting

a veil over everything sexual, over everything in relation to themselves. We do not permit the girls to know anything about sexual matters, and the same with the boys until they discover it themselves. In the public school, in the Sunday school, in church, a great hush comes over the assembly when anything is said about sexual matters. The matters of very highest importance to the human race are the ones which are covered up most deeply and most methodically. Now this, in my opinion, is absolutely wrong from an educational point of view. I know of no earthly reason why boys and girls in school should not be taught at a proper age something about themselves, and while we do have physiologies in the ordinary school course which take this matter up to a certain extent, it is taken up in such a poor, hesitating way by the instructors and by the authors of the books that it amounts to practically nothing. It seems to me that legislation, and the work of the medical profession and the work of the clergy are all, in this line, going to be secondary to what is done in the school. I believe that it is time for the medical profession to make a demand not alone in this phase of the subject but for the more complete education of children upon this subject and at a much younger age.

DR. COLE: *Mr. Chairman,* I learned this morning that outsiders were not entirely excluded from remarks, and I would take the liberty of saying on this subject that there seems to be in all things two sides to a story, and to this one I think we have another side. There is just as large a number of physicians who profit by frightening men as by frightening women. The male side of this story has just as important a bearing on the subject as the other side. How many ads. do we find in the papers for the cure of all weaknesses of men as well as of women, and how much are men, and young men, destroyed by these things, just as are women?

There is another point. It seems to me that city people have fewer children than country people. Now, does not the fact of the houses we live in, the servant question, perhaps, which drives people to boarding, to living in small quarters and in flats, prevent fecundity? I think that is not an unimportant question by any means. We all have cases come to us where a couple would like to have children but cannot have them, or do not have them. Now, whether the difficulty is all on the side of salpingitis, or whether it is on the other side of the question, is one point for consideration, I think.

# REPORT OF SOME CLINICAL CASES.

M. BELLE BROWN,
NEW YORK CITY.

*Mr. Chairman:* I had set apart to-day in which to prepare my paper for this meeting. The news of the death of our martyred President has just reached us this morning. His sad fate is uppermost in my mind as it is in the mind of every loyal man and woman of our country, and I feel I would like to pay him a tribute of respect before commencing my paper. For the past week the overshadowing topic has been the awful tragedy. Only two weeks ago President McKinley was contemplating a pleasant visit to the city in which he now lies dead. To-day more than seventy million people are mourning his loss. While there is no language in which we can forcibly enough express our feeling against the murderous fanatic, who, without provocation or animosity against the head of our nation, fired the deadly bullet, we cannot but feel exalted over the Christ-like manner in which this noble man bore his suffering. We would join the multitude in praise of his character as a man, his career as a statesman, his attitude toward humanity, and his Christian life. His confidence in the supreme power that led him on, "O'er moor and fen, o'er crag and torrent, till the night was gone," did not fail him in his conflict for life, but gave him strength to say: "His will be done."

To see a man die, like President McKinley died, should inspire our hearts to make friends with God. We are proud that America could produce such a man. The record of his life should be heralded to every corner of the earth, that all nations may know we are a God-fearing people.

*Members of the Society*: When the chairman of this bureau called me on the telephone, one hot day last June, and invited me to prepare a paper for this meeting the thermometer in my office was standing at 100°. This intense heat I considered sufficient excuse for refusing any kind of an invitation, excepting one to go to a cooler place, so I very promptly said: "Oh, no, it is too hot to even think of such a thing as writing a paper, besides I have nothing new to write about, and am just about to start on my vacation." He pooh-poohed all my excuses until I finally promised to give him something.

It was my intention to prepare a paper on Physical Diagnosis in Pelvic Disease, but the time is too limited for as lengthy a paper as this subject would require, so I will keep faith with my promise and submit a few clinical cases for your consideration.

Cases No. 1 and 2 were young women of a neighboring city who had been under the care of the same medical attendant for a number

of years. They had been treated and carefully prescribed for mentally, morally and physically, but without any apparent benefit. Their mothers were both widows and obliged to support large families by their own hard work. These girls had become so trying to care for that the propriety of placing them in some public charity institution was being considered.

Case No. 1. This was a languid, feeble-minded young woman, 28 years old. As far as an accurate history could be obtained she was well until about the period of puberty. Her first menstruation occurred at the age of 17. Soon after the establishment of the periods she became listless and indifferent. The flow was painless and for several years regular, but always profuse. As time went on the flow increased each month until finally she had a condition of metorrhagia —in fact was seldom without a discharge of blood. She grew more irritable and showed greater feebleness of mind. She was disobedient to her mother and hard to control. She refused to protect herself when flowing and left evidence of her condition on the street and throughout the house. Her mother had borne with her as long as she could and decided to place her in the alms house unless something could be done for her relief.

She was placed in the hospital in October, 1898, and it was here the writer saw her for the first time. She was carefully examined in every way, as she often had been by her physician, and placed under an anæsthetic for a more thorough examination of her pelvic organs. The external genitals were normal, the uterus, which was somewhat prolapsed, was large and soft, and both ovaries were large as hen's eggs. The patient had previously been prepared for operation if any pathological condition of her pelvic organs was found. After conferring with several physicians who were present, removal of the ovaries was advised and decided upon. The operator believing that the uterus is a useless organ, without the ovaries, removed it along with the tubes and ovaries, the operation being done through the vaginal route. The patient made a good recovery. She remained several months in the hospital in order to be more directly under the care of her physician and to be built up with nourishing food. She showed decided mental improvement before she went home, and since then she has become obedient and helpful to her mother, attends Sabbath school and is spared a miserable, unhappy existence in the alms house.

Case No. 2. This was a vicious girl, wholly without moral sense or delicacy. A sort of a degenerate. She was 24 years of age and had been on the street for years. She was not feeble-minded although of a low degree of mentality. Her mother was contemplating placing her in an institution where she could be guarded for her self-protection and the public welfare.

The doctor was encouraged with the results in the first case and suggested that something, perhaps, could be done surgically for the betterment of her condition. She was given carte blanche by the mother to do anything she thought would either benefit or cure the

girl. She was placed in the hospital and prepared for operation if anything was found necessitating surgical work.

Exactly the same condition was found as in the previous case, viz.: uterus large and soft, with ovaries the size of large hen's eggs. The consulting physicians advised the same thorough surgical work, which was done—removal of uterus, tubes and ovaries. She remained in the hospital four weeks, making a good recovery.

She returned to her mother a new girl. She soon took a position and for the past two years and a half has been able to work and support herself. I saw her less than a year ago and obtained most profuse expressions of gratitude for what had been done for her. She is bright and cheerful and her habits above reproach.

Case 3 is one of a young married woman, 28 years of age, who had petit mal since a girl of 15. Her attacks were at long intervals at first, but the past year they had been increasing in number and severity. She would have four, and sometimes five attacks in twenty-four hours. She showed no heredity of epilepsy or other nervous disorders. She called the attacks "faints" and never knew their significance. The ailment that induced her to seek medical advice was a menorrhagia. A local examination externally showed an adherent hood of the clitoris, the body of the organ being entirely excluded from view. Internally there was an anteflexion of the body of the uterus on the cervix with corporeal endometritis, ovaries normal.

The uterus was dilated, curetted and packed in the usual manner. The hood of the clitoris was loosened, split up on the dorsum, the points of the little flaps trimmed off and cat-gut sutures used to unite the opposing surfaces. The wound was dressed and patient returned to bed. Four months have elapsed and there has been no return of the "faints."

In the practice of medicine many difficult problems present themselves. In the first and second cases the question may be raised, Had any one a right to remove the pelvic organs of these two young women without their consent? Let us see. In the first place neither of them had sufficient mental endowment to judge for herself; in the second place they both had diseased ovaries, and in the third place they were soon to be placed in institutions to be supported at public expense.

If moral perversion, irritability and bad temper have their origin in the abdominal and pelvic cavities, as some specialists in mental and nervous diseases are inclined to think, these two cases were certainly good illustrations of the theory, as their improvement after operation showed the source of a large part of their trouble was from pelvic pathology, the reflex to the nervous system being cut off by removal of the irritating organs. Medicine, hygiene and moral suasion had done nothing in either case. If surgery was to do anything, thorough work was better than half way work, hence removal of uterus and tubes along with the ovaries. In neither of these cases was any brain lesion diagnosed. The work was purely

surgical for local pelvic pathology, supposed to be producing functional reflex nervous disturbances.

In the first case the mental feebleness was no doubt due to anæmia of the brain and lack of nutrition. The constant loss of blood kept the patient below par in every respect. After the operation there was improved nutrition with restoration of physical health and a better mental condition. In the second case the young woman was rescued from a life of degradation and the public welfare protected.

Perhaps surgery could diminish the number of paupers and inmates of our charitable and penal institutions. If only a few could be benefited it would be worth while. It is a grand thing to lift a human being out of darkness into light, out of misery into comfort, out of dependence into independence.

Every general practitioner, in fact, every physician, whether specialist or in general practice, should make a study of reflex neurosis. While recognizing the difficulty of differentiating between functional and organic disease the fact should not be lost sight of that no part of the body is an independent tissue.

I have not had experience in surgical work where mental and nervous disease has been accompanied by brain lesion, but that functional brain troubles may be relieved surgically when pathological changes in remote organs and tissues are found, I am confident.

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# SEXUAL NEURASTHENIA.

A. R. GRANT,
UTICA.

In selecting this topic I desire to call attention briefly to a certain class of cases of nervous exhaustion in the female which is common in every physician's practice. These cases give a history of having been perfectly well until after the birth of the first—or perhaps the second child, when a variety of symptoms develop, which gradually increase in number and severity until a recounting of their various aches and pains seems to point to disease of every organ in the body. They have headache, both vertical and occipital; dragging pains over the hips, with inability to stand long at a time or sit still in church or theatre; they may have numbness in their arms and hands; they feel as if they would cry if spoken to; many have marked stomach symptoms and very often this dyspepsia is the ailment for the especial relief of which they first apply to the physician. They become irritable and hard to get along with in the home, the husband often complaining that the wife is not what she used to be in disposition,

and also that she complains constantly and seems to have a new ache or pain almost every day. In the early stage of this condition the patients sleep well but complain of feeling exhausted in the morning; later, sleeplessness is a marked symptom. Frequent urination is present in one-half of all the cases; they usually grow thin and anæmic, the whole aspect of the woman being that of suffering from a multitude of ailments and discouragement at her inability to perform her usual duties.

Physical examination of chest and abdomen is usually negative of organic lesion, capable of producing any such group of symptoms. Pelvic examination gives the clue to the constant irritation which has been the cause of the nervous condition outlined above, undoubtedly by reflex action by way of the spinal ganglia and sympathetic plexus. There will be one or all of these conditions.

Pain on bi-manual examination; a sensitive cervical tear; a heavy uterus with endometritis and possibly ovaritis or salpingitis; a cystocele or rectocele with relaxed vaginal outlet which allows the uterus to prolapse or the fundus to assume a posterior position in the sacral hollow. From the os exudes a thick mucous discharge; this constitutes fairly the common condition irrespective of rectal affection.

Now the question is, will the indicated remedy with or without local applications cure these cases? I believe they will do no more than temporarily relieve, and that when the treatment is discontinued they will relapse into the old condition. Prophylaxis depends upon keeping the perineum intact in confinement and the fundus anterior, during the puerperim by prescribing the Sim's position for the woman during full two weeks following labor.

The treatment that is always gratifying and uniformly successful can be briefly stated, and it seems to make little difference whether the pelvic conditions have existed three years or thirty years as far as practical results are concerned except that the older cases are slower in reaching good health.

Pelvic repair and uterine reposition in a suitable hospital where the patient may have from two to four weeks of absolute rest from all care and responsibility. Forced feeding, especially with foods rich in fats, commencing with very small amounts in the worst stomach cases and rapidly increasing in quantity and variety. The exciting cause being removed the indicated remedy will now be efficient. Nux vomica and iron are essential aids in attaining an increase in weight and nervous vitality. Treated in this way these patients whose office and home treatment is most discouraging in permanent results become well and strong, increase in weight, forget their old fears and pains and are among the most grateful and satisfactory of all.

# REPORT
OF THE
# BUREAU OF NEUROLOGY.

"Spiritualized Food for Mental Invalids," - - SELDEN H. TALCOTT.

## SPIRITUALIZED FOOD FOR MENTAL INVALIDS.

SELDEN H. TALCOTT, M. D.,
MIDDLETOWN.

It was a philosophical psalmist who wrote: "Better is a dinner of herbs where love is, than a stalled ox and hatred therewith." The principle of accepting food from an ideal standpoint was understood by the wise men of the East thousands of years ago. It is a principle that should be exemplified not only in every well-regulated household, but also in every hospital designed for the care of the sick.

Mental invalids, especially, need a diet that is replete with spiritualized influences,—a diet that is consoling, stimulating, inspiring and nourishing to the utmost degree. But how shall such food be spiritualized? This end is attained most surely by appealing to the soul through the physical senses. All food for the use of the sick should be prepared with a view of pleasing the mind. The fragrant odor of herbs rising to the nostrils from a well-cooked dish, stirs the soul with happy anticipations of a gratifying feast. Spotless linen, dainty tableware, decorations of fruits and flowers, and the artistic arrangement of each dish, kindle, through the eye, the enthusiasm of the prospective eater, and prepare the stomach for the food which is to come.

Again, food is spiritualized by associating the act of eating with some blessed and golden memories of the past. Who does not enjoy the fond recollections of one's youth and adolescence when these bring back to mind, through the mist of years, sweet thoughts of the pies, and puddings, and tarts, and cakes which "mother used to make"? The pleasant dishes of childhood were all spiritualized by the love of a mother or a sister.

We all remember the delgihtful days of the summer picnic, when in the green woods or upon some rocky coast, we felt not only the

spirit of freedom from care and the happiness of pleasant association with our friends, but likewise the keen pangs of pleasant hunger which made all kinds of food acceptable, palatable, and digestible. Under the spiritualizing influences of the scenes and the surroundings, we converted hard-boiled eggs, cold milk, pickles, railroad sandwiches, jam, and jam cake into pure American blood without a single painful hitch in the digestive apparatus, or a single slip along the trolley of emulsifying conversion of old cake to new corpuscles.

The preparation of the patient himself for a coming meal is a task that should be performed with due consideration for the spiritual side of life and living. The clean basin of water, the elaborate brushing of the hair, the neat and tasty adornment of the person, and the kindly word of good cheer,—all these are preliminary necessities for the administration of nourishment to the sick body and the tired mind.

The influence of national dishes, and their effect upon the minds of patriotic citizens, should likewise be considered. Sourkraut and beer and pretzels create bliss in the soul of the Teuton, and make easy work for his stomach. The memory of oatmeal porridge, prepared and consumed upon his native heath, gives inspiration and joy to the ambitious and wiry Scotchman. The Englishman "in every land, 'neath every sun" draws his powers of body and activities of brain from English roast beef, and Yorkshire pudding and brown stout. The optimism of the Irishman is as unquenchable as the rays of the noon-day sun so long as he can fill his stomach with good potatoes and boiled pig, and warm the cockles of his heart with a drop of his native poteen. The Italian spiritualizes his grapes and maccaroni. The Frenchman is happy with dainty salad, and vin ordinaire, and cordwood bread. Rice makes happy the Chinaman, while raw fish and *silsalet* are the spiritualized delicacies of the Norwegian.

We have a cosmopolitan nation, and hence we should seek to monopolize from every source all that is best and most inspiring for every class of American citizens.

The value of a happy mental state while eating one's dinner is a matter that is imperfectly understood by the masses. The sick should be encouraged to realize the importance of idealizing their food, and of thus securing from it the greatest possible benefits. The sick should become Bohemians in spirit and in action to the extent of making the best of everything in life, and of minimizing their troubles, and griefs, and privations. The Bohemians live high if they can, economically if they must, and happily at all times.

"The trout, the grouse, the early pea,
By such, if there, are freely taken;
If not, they munch with equal glee
Their bit of bacon."

If the spirit of the Bohemian could be injected into the heart of every case of depression, and if the inception of food could be made at all times under joyous and spiritualizing influences, then the bat

of melancholy would be driven out of the human temple, and peace and contentment would form a new and holy alliance with happiness and hope.

It is undoubtedly true that a finer quality of food, and a more generous quantity, is needed to build up nerve tissues than is required for the upbuilding of the muscular structures, or for the laying on of fat. The nerve tissues are more delicate and refined than either muscle or fat. The nerve tissues are dainty in the selection of food most needed for their health and strength. Nerve tissues cannot be rebuilt by putting into the stomach, without regard to spiritual considerations, a given quantity of certain chemical compounds known as food. The science of living cannot be circumscribed by the cold, calculating principles of modern but cheap chemistry.

In our experience, we have found that the insane need, at the outset, a hot liquid diet, composed of milk, soups, gruels, and beef tea. We have used for many years a mixture of beef tea and milk. The former is valuable as a stimulant, and the latter, as a nutrient. These articles should be served in a most appetizing manner. With a dose of milk should go a small tray covered with white damask, a glass goblet, a china pitcher, a silver teaspoon, a small salt cellar, and a snowy napkin.

After a hot liquid diet has fulfilled its purpose, then solid food, consisting largely of the various native and imported grains, together with vegetables and fruits, and a very moderate supply of meat, may be given. Rich and stimulating red meat is sometimes good for cases of melancholia, but cases of mania and general paresis should be restricted in the use of meat. It sometimes stimulates too much those who are excitable and nervous.

Concerning diet for the insane, Sir Arthur Mitchell, of Scotland, has declared that under some circumstances a patient will thrive on sawdust pudding, while under other circumstances he will starve to death on beefsteak and porter. We should ascertain just the variety of food that is best for each individual case, and then we should administer it in such a way as to make it satisfying and agreeable. One of our patients suffered from severe dyspepsia for a number of years, and most of the food which he ate produced active distress and acute pains in his stomach. When he came under our care he was greatly emaciated, and profoundly depressed in mind. After many experiments, we ascertained that he could take hot milk, broiled lamb chops, baked potatoes, and toasted bread without any discomfort. Consequently we gave him milk, lamb, potatoes, and toasted bread morning, noon, and night for over two years, and from a living skeleton he became a healthy and happy man, his indigestion having been entirely relieved by medication and acceptable diet,—chiefly, the latter. It is a strange fact that this man while taking a monotonous diet, composed of four kinds of food, three times a day for over two years, did not tire of it in the smallest degree. In fact, he kept up the diet for several years after he returned home, and he continued to enjoy good health and serene

happiness. Monotony of diet seemed to him a circumstance unworthy of even passing notice, considering the relief he obtained from its persistent use.

A change of climate and diet sometimes constitutes the means for improving the condition of both body and mind. A person who has lived on boiled mutton, and roast beef, and fricasseed fowl in the mountains until the sight of food is distressing, will often regain his appetite and his normal spirits by a sojourn at the seashore, where he can subsist upon fish, clams, oysters, lobsters, crabs, and other easily digested substances.

Finally, we wish to emphasize the importance of encouraging the sick to accept nourishment in a happy and contented spirit. The spiritual sense should be invoked by means of association, comparison, and recollection; and it should be the aim of every philosophical physician to treat the sick with a due regard for those influences which are above and beyond those groveling things which are "of the earth, earthy."

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# REPORT

OF THE

## BUREAU OF OBSTETRICS.

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"Experience with Oxygen in the Resuscitation of a New Born Infant," J. W. SHELDON.
"Douching," - - - - - - A. LENORA WHITE.
"Acetate of Copper as an Oxytocic," - - GEORGE F. LAIDLAW.
"An Obstetrical Anomaly," - - - - - B. WILLIAMSON.

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## EXPERIENCE WITH OXYGEN IN THE RESUSCITATION OF A NEW BORN INFANT.

J. W. SHELDON,
SYRACUSE.

The rather lengthy title of this very brief paper is, as announced, "An Experience with the use of Oxygen in Resuscitation of a New-Born Infant." To my mind, the treatment of asphyxia in the new born is well worth a few moments' consideration.

In this learned body a mere reference to memory suffices to set forth the distressing picture incident to the closing of a life just about to begin.

The case which forms the basis for this simple clinical report presented a set of symptoms representing the graver form of asphyxia.

The mother of the infant in question, a primipara, was seized with puerperal convulsions during the second stage of a severe and tedious labor. Vigorous measures were, of course, used to meet this emergency. As soon as possible forceps were applied and every effort made to hasten delivery, which, however, could not be effected as rapidly as I wished. Before it was accomplished five convulsions had occurred.

Under these circumstances, feeling the utmost solicitude for the safety of the child, thorough preparations for its resuscitation were made before delivery. A table was prepared and everything placed in readiness including hot and cold baths, instruments for withdrawing mucus or other substances from the respiratory passages—in fact, all provisions that could be thought of.

When this case took on a grave aspect, I had called in consultation two of the most able and best known of our local physicians. To one of these was assigned the care of the infant.

The child was born pale and limp, respiration was slow and imperfectly performed and became slower until only a gasp could be observed two or three times per minute. Muscular tone and reflexes were absent. Everything denoted a most alarming form of asphyxia.

The usual means for resuscitation failed. Every effort was made to excite respiration but without success. The heart beat became imperceptible, the extremities were motionless, the body cold and of a deathly pallid appearance. To all intents and purposes the child seemed dead in spite of the doctor's efforts.

Believing that improper aëration of the blood—a lack of interchange of oxygen and carbonic acid gas was the cause of the trouble, we persisted in our attempts, using the inverted posture with warm flannels applied to the surface of the body and continuing gentle manipulations for artificial respiration. This was varied by mouth to mouth insufflation. Nevertheless no satisfactory progress was made.

Although I had never known or heard of its employment for such purpose, it occurred to me that oxygen, our friend in so many other emergencies, might be of use. Fortunately a horse and buggy stood at the door. A messenger was dispatched post-haste to the Homœopathic hospital, a quarter of a mile distant, the nearest point at which oxygen could be obtained. He made quick time, returning with a tank of the gas.

Artificial respiration was utilized, in addition to the force of the liberated oxygen, to get it into the lungs. Within a remarkably short time after beginning its administration a change in the child was perceptible. The color of its face and lips first changed, pallor

giving way to a wholesome flush, this extended to and over the body until the entire surface could be observed to take on a rosy tint. Respiration was gradually re-established, the child grew warm, showed other signs of returning life and recovered. It was the opinion of all of the physicians present that, without oxygen, the infant could not have been saved.

It should be added that the mother, although suffering two severe post-partum convulsions within the first twelve hours, survived and made a fine recovery.

The idea of using oxygen under such circumstances was purely a thought that came to me in that emergency, and I have since that time fancied that such of my colleagues as may not have personally used or known of oxygen with reference to this class of cases, might welcome another expedient to be laid up against the evil dav. (Applause.)

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## DISCUSSION.

DR. DANFORTH, of New York: I think the contribution made by Dr. Sheldon to the treatment of asphyxia natatorum by means of oxygen is a most valuable one, and I shall avail myself of it in the future in cases of that kind. I do not know that it is necessary to discuss the paper. It requires no discussion. The treatment of asphyxia natatorum is well known to all of us, the various expedients which we employ, one after another, in the resuscitation of infants nearly dead from asphyxia. Oxygen, I should think, would be most valuable. I have enjoyed very much listening to this paper.

DR. FISK, of Brooklyn: I would like, Mr. Chairman, to add a word to Dr. Danforth's in appreciation of the completeness of the paper. As I listened to it I tried to think of a number of expedients that I might suggest after the paper was read, but I found the writer had tried them all before he got through, and to those of us that are in cities where oxygen is available and where it can be procured in as quick a time as Dr. Sheldon was able to get it, it certainly opens to us an opportunity that, with the experience of years, there are very few of us but that have met those cases of asphyxia in which we should have been glad to have known of this before.

CHAIRMAN HOWLAND: Dr. Sheldon, I would like to ask you one question regarding the administration of this oxygen, as to just the definite manner in which you did this. Did you allow the oxygen to escape directly from the tank into the child's nostrils, or did you mix it?

DR. SHELDON: In answer to that question, Mr. Chairman, I will say that the oxygen was administered by myself, with the greatest precaution, as gently as it was possible to induce a current of the oxygen from the tank and yet have any oxygen, commencing, as you might say, almost imperceptibly, or with as slight a flow as it

was possible in my judgment to give, and that tube was introduced in the mouth.

PRESIDENT GREENLEAF: And you made pressure on the thorax at the same time, and then remitted the pressure?

DR. SHELDON: The physician that was assisting made the artificial respiration by the chest actions, which, of course, enabled the oxygen to flow more readily into the chest. As Dr. Fisk has said, I had tried all the remedies or means and methods of resuscitation,—I do not think I would wish to be understood as saying that I had actually tried all,—but such as in the emergency of the case I could think of. I thought of electricity afterward, but I never shall use it when I can get oxygen, from this experience; and what was very gratifying to me, there was an allopathic physician of unmistakable ability present, who was called in aside from the consulting physicians I had there, two homœopathic physicians, and he was a cousin of the mother; and when the child had recovered apparently, he turned and said to me, "Doctor, I want to say something to you. Up at St. Joseph's Hospital,"—with which he is connected,—"we had a case of a child there,"—a charity patient, of course,—"where the nurses worked over the child for an hour and lost it, and we had oxygen down stairs." But he didn't know of it; and, he said, "I think they will try it in St. Joseph's Hospital." Well, that was very gratifying to me, to think that I had a little endorsement of my views, that came up in such an emergency as that.

DR. FISK: This is an accident that is liable to come to all of us when we least expect it. In fact, I think there is no condition in our whole practice where we have to be more prepared for all emergencies and where we never know what we are going to meet until the event. I want simply to mention one method to be tried, which I have spoken of in the Society before, I think some three or four years ago, where oxygen is not available, by which I have saved the lives of two infants,—and I would state also that I never cease trying to resuscitate for at least an hour. In both of these cases there was no perceptible heart action. There was no evidence in any way that there was any life in the little infant. The method I refer to is the dilating of the sphincter ani. The shock of that to the infant will start up a respiratory action as promptly as that (clapping hands), and I think that inasmuch as in the cases of appendicitis that we have here every meeting, and in which we are continually reminded of what we should do, the simple statement of this little matter of stretching the sphincter is an expedient that it is well for us to remember and which is worthy of mention.

# DOUCHING.

A. LENORA WHITE,
NEW YORK CITY.

Perhaps, in this age of exhaustive researches, it will no doubt savor of egoism to hope to present so old a topic as douching in a new light. I do not expect to enlighten you on douching as a remedial agent, but I want to relate two or three histories which I think will illustrate my method as an assistant in the treatment of gynæcological and obstetrical cases.

I find that nearly every woman objects to the bother attached to taking a douche. One patient said to me, "Do anything to me, doctor, even remove my uterus, but don't order me to take a douche." I asked her why? "Because, for the last two years I have spent about four hours a day taking my douches until they have become a bug-bear." I then asked her how she took them.

She replied, that the doctor had ordered her to take her two-quart bag twice full, and she was obliged, according to his instructions, to take them lying down. "I have first to heat my water, get my rubber sheeting, fix my bed and then make my solution, fill my bag, take my supine position, and after the first bag has emptied itself, I must get up—get more water (for by that time the solution has cooled), and go through the same maneuvers for the second bagful. Then, I am ordered to lie still for twenty minutes. I cannot lie still upon a full douche pan—and must of necessity, get up to remove it. I become so nervous and fretted before I have finished I could scream."

This has voiced the sentiments of so many patients who have come under my care, that I felt that I must devise some other method of taking a douche.

I have been employing now for years this plan: First, I ask my patient, if they are able, to buy a very large douche bag; if not, I ask them to purchase a wooden pail, bore a small hole near the bottom, into which fit a half-inch rubber tube the required length, first inserting an inch of glass tubing to insure the aperture; the stop attachment and vaginal tip can be transferred to the other end of the tube, and you have a simple, inexpensive and easily replenished douche bag. Then I direct my patient to have a small shelf made in the lavatory closet about four feet above the seat; on this, she places her pail, or hangs her large bag and takes her douche seated on the closet.

The mode of procedure is as follows: After inserting the vaginal tip from the front, she closes the labia majora around it with her

right hand between her legs. This will cause the entire vaginal cavity to become completely distended, and the medicated water is distributed more thoroughly over the mucous membrane than it was ever possible for it to be under the old method of lying down.

When the vagina is filled, and the water percolates through the medium of the least resistance, i. e., the vaginal orifice at the point of insertion—the patient relaxes her hold quickly and allows the retained fluid to gush out, bringing, by its force, all the tenaceous mucous secretions which are usually undisturbed by the gentle irrigation in the lying down position.

Then the parts are closed around the tip again, and the same process is repeated, until the required amount of water has been taken. The patient can go at once to her couch and rest without the annoyance of putting away things. The pail can be wiped out and the tube coiled inside of it until needed again.

I have obtained some gratifying results by employing this method of douching; noticeably, the douches were regularly and conscientiously taken, and as we all know, that is the *sine qua non* for success in douche treatment. I have increased the quantity of hot water to be used as I thought the case needed, and also according to the improvement made. I have used as much as five gallons of hot water three times a day. Another advantage claimed for it is, that of mechanical massage (if we might employ such a term). Suppose our case is one of chronic metritis, or parametritis—the two conditions that yield slowly, if at all, to the usual local applications. In such cases, the cellular tissues around the uterus, and its appendages, have become inelastic from chronic inflammation; and the constant repetition of such quantities of hot water depletes the parts, carries forward the blood currents, stimulating the absorption of the waste materials. The gradual distention of the vagina, and the sudden relaxation, gives us a mechanical manipulation of no mean value.

I could give you results of this method in many cases whose histories would differ only in slight detail, but I will content myself with two, which will possibly interest you.

No. 1. A young girl, while skating, fell, striking her hip heavily. Soon after walking home she became very faint and began to flood. The family doctor, as well as a specialist, were in attendance for months. I do not know what the diagnosis was, but she tells me she lay two months with her hips elevated, and any relaxation from this position caused profuse hæmorrhage. From the symptoms and treatment, she must have had traumatic peritonitis with effusion. She came under my care six months later. She gave a history of hæmorrhagic dismenorrhœa. The flow was so profuse, it was alarming during the menstrual periods. Her menses were irregular; sometimes they would be every six weeks; and sometimes they would last two months, flowing more or less freely. She had had the best of care and advice. The eminent surgeon who had been consulted said there was no remedy but the knife. In fact, when she came to

me I thought so myself. But the patient begged me to try something else first. Of course the outlook was not encouraging, but since she was willing to assume all risk, and was able to pay for the experimenting, I decided to take the case. I will not go into the subjective history, but digital examination revealed a mass about the size of a cocoanut in the left iliac region, a little posterior to the uterus, which was displaced toward the right. She flowed profusely after the examination.

We began with three gallons of hot water, three times a day. Chloride of sodium was used in solution, about a teaspoonful to the pint. The quantity of water was increased each week, as the patient improved. At the end of two months, she was using four gallons t. i. d. and the mass had entirely disappeared and the menses were regular and normal. Nine months after she came to me, she was married, and a year after, she was pregnant. Her health is perfect. It is now three years since she has been treated. I used the indicated remedies, but erigeron$^{3x}$ was my chief drug. All the results have been satisfactory in my gynæcological cases from this method of douching.

No. 2. Was one of puerperal insanity. With every child the woman became insane. She had varying degrees of mania; with one child, it might be slight; with another, she might have to be sent to an institution. She had spent a year in an asylum after the birth of her last child, eight years before. Of course, the family were anxious, and so was I.

The baby was born after a very normal and easy labor. Immediately, I gave my patient bella. $3^x$ ʒi q. 2 hr. and ordered the nurse to give her every three hours, two gallons of hot salt water, as a vaginal douche. On the second day, her temperature rose, and I washed out the uterus with a small piece of cotton on an applicator. For this purpose I used a carbolized solution. A few small clots were removed from the uterus. The temperature which had been only as high as 102 degrees, fell to normal, and the patient made an uneventful recovery and has been perfectly sane now six years. On the fifth day, the douches were given three times a day only; but the quantity used was never less than three gallons.

She has had no more children, and I have, therefore, had no opportunity of proving anything further by her, to my great regret—and I have never had any other case of mania to prove my theory of frequent and copious hot douching.

# ACETATE OF COPPER AS AN OXYTOCIC.

GEORGE F. LAIDLAW, M. D.,
NEW YORK.

Acetate of copper in doses of one-quarter to one-half grain is of real service in hastening the progress of tedious labor. Tedious labor is a condition, not a theory. It occupies a place in every text-book on obstetrics, under the head of delayed labor, prolonged, protracted, tedious or powerless labor, uterine feebleness, inertia, atony or paralysis. Tedious labor has no precise time limit. In a process like labor, the normal duration of which is from half-an-hour to a week, it is difficult to state in precise terms just what constitutes the condition. The physical condition of the patient, the character of the pains and the progress or lack of progress they make are factors equally important with time in determining the extent of tedious labor or uterine inertia which demands the interference of the physician, for tedious labor is a condition in which the physician should always interfere. Sir James Simpson "proved conclusively that both the maternal and fœtal mortality were greatly increased in proportion to the entire length of labor."*

Leaving out of consideration anatomical interferences to delivery, as deformed pelves, monsters and locked twins, which are among the rarer phenomena of obstetric practice, I confine my remarks on the acetate of copper to the more frequently occurring cases where the difficulty is physiological and with the soft parts, insufficient contractions or rigid os; or that debatable condition, spasm of the internal os; or rigid perineum, the frequent occurrence of which I am also inclined to doubt for in the few cases of apparently rigid perineum that have fallen to my lot, I have always been able to make out a firmly constricting cervix about the fœtal head.

The interference with protracted labor that is justified and necessary is laid down in all the text-books. I will not go over the ground of opium, chloral, quinine, ergot, mechanical dilatation, compression and forceps. I will presume that the physician will bear in mind the necessity of evacuating the bladder and rectum. I will simply add to these well-known resources in tedious labor the use of the acetate of copper.

The first patient to whom I gave acetate of copper as an oxytocic had been in labor sixteen hours and had delayed ten days over the expected time of delivery. At the sixth and eighth hour she received thirty drops of fluid extract of ergot and ten grains of quinine with the result of obtaining stronger pains but no progress of the head,

*W. S. Playfair, Science and Practice of Midwifery. 1898.

which was in normal presentation and firmly held by the cervix at a dilatation of three inches. The waters had come away early. At the end of fourteen hours, the pains died away and for four hours there was no further effort. I had read in Rademacher that copper was anciently in high reputation for stimulating the pains of labor and concluded to give it a trial, as the good condition of the patient justified temporizing with drugs and did not seem to demand instrumental interference. I administered ten drops of Rademacher's tincture of copper* and mixed sixty drops in four ounces of water, of which a teaspoonful was given every fifteen minutes. Within two hours the pains reappeared vigorously, the head progressed rapidly and delivery was accomplished in three hours from the first dose of copper. The placenta was delivered easily in half an hour, a moderate perineal laceration was repaired and the patient made a good recovery.

In this case you may think, as I did, that the action of the copper might have been confused with that of the preceding ergot, or that the ergot caused cervical spasm and that this spasm either relaxed spontaneously or was dispersed by the copper; or again, that it was only natural after a period of quiescence for the pains to return with vigor and complete the delivery. In this case, the quinine had little influence. The expulsive action of the ergot had ceased and our judgment must decide between the copper and natural recovery of power. As the acetate of copper is a perfectly safe drug in these doses, I concluded to test the matter further and next gave it to a primipara who had struggled with ineffective pains of the first stage for ten hours. Quinine in two ten-grain doses increased the pains but brought no real progress. I gave ten drops of the tincture of copper every fifteen minutes for four doses. In one hour, vigorous pains appeared, the waters came away and delivery was accomplished in two hours and a half from the first dose of copper.

Next I gave it to a multipara in her fourth confinement after six hours of dry labor with delayed cervical dilatation. In this case, I have no record of the dosage given but I remember distinctly the promptness of the appearance of effective pains and their satisfactory conclusion.

I recently attended a mother in her second confinement. Her first child had been born five years before and had required a labor of fourteen hours. With the second child, the pains came on at ten o'clock in the morning but did not become severe and effective until four in the afternoon, when I was summoned. The cervix had attained a dilatation of less than two inches and the bag of waters was unbroken. Returning in two hours and finding that, in spite of vigorous pains, the cervix remained about the same size, I gave her thirty drops of the tincture of copper and left two other doses to be given at intervals of half an hour. Returning at the end of another hour, I had the satisfaction of finding the cervix already four inches in diameter and by a succession of vigorous pains, with

*A solution of 7 grains acetate of copper to one ounce of alcohol and water.

short intermissions, the child was born in two hours and a half from the first dose of copper.

Another more striking instance of the action of copper during labor occurred in a primipara in whom labor commenced on the two hundred and eightieth day with vigorous pains which continued for five hours and then died away. Slight, ineffective pains came at intervals of thirty minutes for several hours. Within thirty minutes of the first administration of thirty drops of copper tincture, the vigorous pains reappeared and dilatation and expulsion was complete in one hour from this time.

In another case, after eight hours' fruitless efforts, with dilatation of the cervix advanced to a diameter of only three inches, and the bag of waters unbroken, a thirty-drop dose of the copper tincture repeated three times at intervals of twenty minutes brought on the usual vigorous expulsive pains and delivery was completed in about two hours.

This comprises my experience with acetate of copper as an oxytocic and covers a space of three years. I am not partial to forceps and believe that in spite of the most careful handling the danger of injuring the child is great, and perhaps this has led me to delay longer than is the habit of some physicians for the development of the natural expulsive forces or their stimulation by drugs. I am satisfied that it is possible to so stimulate the pains and that the most reliable drugs are quinine and acetate of copper. In Guernsey's and in Sheldon Leavitt's books on Obstetrics, there are given the indications for many drugs in uterine inertia. I have tried them faithfully in my early practice and was so uniformly disappointed that I do not now look for a similimum. Quinine and copper seem indicated in different cases but it is only by trial that their applicability can be determined. I believe them to be harmless and without the risk of ergot. I have used ergot to some extent during labor and while I have not observed the uterine spasm with its attendant evils that is commonly attributed to its use, still I would rather replace it by a drug of less sinister reputation.

The acetate of copper is harmless in the dosage given. I have used it about five years in many diseased conditions, from infancy to old age. Its only unpleasant feature is its nauseating action, but this is only observed in certain sensitive cases and can be controlled by giving the dose in milk or coffee or lemonade. I have carefully examined the urine of patients while taking the remedy and have seen no bad effects. Copper does not produce the tonic uterine contraction that is attributed to ergot, but frequent, powerful, expulsive pains with distinct intermissions. Under its action the rigid cervix relaxes, whether due to the power of the pains or to a specific relaxing effect of the copper. I think that it is force of the contractions of the fundus. In copper cases, I have not seen any more damage to the perineum than in undrugged labors. There is no tendency to retention of the placenta. In fact, the placenta often seems to be expelled into the vagina with the last pain that brings the baby.

There is absolutely no tendency to post partum hæmorrhage after the use of copper, and the lochial discharge is apt to be scanty and of short duration. Copper can be used in any stage of labor and while I would use smaller doses in albuminuric cases, I have never seen any unfavorable urinary symptoms from its use. As already stated, copper will not correct a deformed pelvis or deliver monsters or empty the bowels or bladder; but in ordinary cases of tedious labor from uterine inertia or rigid cervix, the drug has done effective work and it has done it according to the long-established principles of our art, quickly, safely and pleasantly.

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## DISCUSSION.

DR. HAMLIN: *Mr. Chairman,* I must confess that I am not so well acquainted with the works of Rademacher as my friend, Dr. Laidlaw, and I must also admit that this drug, acetate of copper, as an oxytocic has never been used by me. I have no experience in its use. In my opinion, in the majority of cases of delayed labor, the cause is to be found, however, in some mechanical interference with the progress of the presenting part. Many cases of tedious labor which occur, in the first stage, are due to incomplete flexion of the head. Now, I am not prepared to say that acetate of copper will not help to induce a more complete flexion, but I would scarcely be prepared to admit that. Given a head which is in an incompletely flexed position, an increase in the pains, or the driving force, it seems to me, would rather tend to give you an extension of the head than a more complete flexion. I must say that in my practice I very, very seldom have occasion to resort to any oxytocic whatever. The majority of cases, as I say, to my mind, can be explained, if a thorough examination and a careful diagnosis is made, by some malposition, malpresentation or some anomaly of the expelling force; that is to say, by a pendulous abdomen or something of that kind, so that the direction of the driving force of the uterus is not in the pelvic axis. I have had a somewhat extended experience in obstetrics for the last twelve or fifteen years, and as I recall it now, I have never had occasion to use quinine or any other remedy outside of the usual homœopathic remedies to expedite labor; and, contrary to the experience of Dr. Laidlaw, I have found those homœopathic remedies very efficacious in the treatment of delayed labor, such remedies as belladonna, podophyllin, gelsemium and other remedies which are familiar to you all,—chamomilla, caffea,—those remedies have been very successful with me. In cases where the head has progressed through the canal, dilatation is complete, and you have delay in the second stage of labor; also, contrary to the experience of Dr. Laidlaw, I am accustomed to rely upon the forceps, and I believe that with skillful work the forceps is almost devoid of danger to the child, and, I think, a great means of safety to the mother.

DR. DANFORTH: I think there is such a condition unquestionably as inherent weakness of uterine pains. We meet with that condition at the bedside, where there is a normal presentation,—so far as we can ascertain by a casual glance, at least, there seems to be no obstacle to the progress of labor, except insufficient pains. In such cases, as Dr. Hamlin has said, and as Dr. Laidlaw intimates, we have very valuable remedies. I, too, have found that the homœopathic remedies like gelsemium, podophyllin, pulsatilla, cimicifuga chamomilla, have the most marked effects in harmonizing uterine action, whether it be deficient or excessive. I may say that I never used ergot in the first stage of labor. I very, very rarely have recourse to quinine, very rarely have recourse to any medicine except the homœopathic medicine as it may seem to be indicated; but I quite agree with Dr. Hamlin in that after I have used the remedies as they seem indicated, I usually find that their failure is due to some mechanical impediment to the progress of labor; and one of the most common causes of delayed first stage, I think, is an occipito-posterior presentation of the head. Physicians are too apt, I believe, to rest satisfied and contented with the mere diagnosis of a head presentation. When they feel that round, smooth, ovoid surface so indicative of the head, they are content and the case is allowed to go on in the natural way, until, after a time, two, four, six, eight or ten hours,—however long it may be,—they find that the pains have come to a standstill; and if the physician at such a time will investigate still further, go beyond the mere diagnosis of a head presentation, he will find that there is a mechanical cause in the nature of an occipito-posterior presentation, preventing a flexion of the head,—a failure of presentment of the occiput,—a mechanical condition that prevents flexion of the head,—some mechanical impediment. I find that the cervix dilates best when the uterine force is good and the head is presented correctly. That is the great point. The diagnosis, I think, is very essential to the successful management of the case. So far as the acetate of copper is concerned, I have never used it. I am glad to know about it. I will avail myself of that drug at the very first opportunity.

If I may be allowed to say a word more I would like to recite briefly a case which occurred in my practice two weeks ago, a primipara, which entered upon the first stage of labor with the most encouraging pains. I felt satisfied that the outcome would prove favorable, and within a very reasonable length of time I observed a head presentation and was therewith content, although, as I afterward discovered, the anterior fontanelle was right in line with the os, which is unusual in occipito-posterior presentations. It was an occipito-posterior presentation, as it turned out to be, with very partial flexion of the head. The posterior fontanelle was in the right posterior part of the pelvis; the head was only slightly flexed. I gave medicines to the best of my ability. I indeed resorted to ten grains of quinine. The pains would be instigated to greater activity for a short time, and then would subside. The cervix dilated slowly

in spite of remedies. The cause of delay was the inability of the patient to move that head one iota, on account of the mechanical disadvantage under which she labored. The position of the head was such that she could not move it through the long canal from the posterior right part of the pelvis to the right anterior, and it was only after I had placed my patient under the influence of chloroform and had rotated the head with my hand, lifted it up and rotated it partly, that she made better progress, and even then she could not succeed, and finally I had to put on forceps and deliver her, which I did without any difficulty. I think if I had allowed that woman to go for two, three or four hours more, giving the medicines, I should have lost the child, and the mother would have been in a much more serious condition than she was after my very safe forceps delivery. I merely wish to emphasize the point, not that remedies are not useful,—they are extremely so, and I believe that the acetate of copper will probably prove a valuable aid to our remedies for these cases,—but that as skillful physicians we should endeavor to diagnosticate the cause of these delays, which will be found to be some mechanical defect. (Applause.)

DR. COLE: *Mr. Chairman,* there are two points which suggest themselves, which I have met with, that have not been mentioned. I suppose they are common to everybody. One is the presence of too great a quantity of fluid in the uterus. When we get an object of a size that we can comfortably grasp, we can often crush it. If it is very much larger we cannot get any grasp upon it. That was not mentioned here. Another point,—a change of position of the mother will often make a decided difference in the position of the child. That Dr. Danforth has spoken of, turning the patient upon her side, or upon the other side, depending on the conditions present, will make a decided difference in the position of things, and in one case where I tried that we had a very fortunate outcome and the child immediately came along. But I have found a great many times that there is more fluid in the uterus than it can grasp, and you get no pressure upon the child whatever, and a very small opening; but, allowing part of it to drain away, if an opening has to be made before the dilation of the uterus,—will produce a very decided difference in the progress. I am decidedly in favor of the homœopathic remedies, but have never happened to use the acetate of copper.

DR. FAUST: I would like to ask Dr. Laidlaw exactly what the proportion of that tincture is, or just exactly what tincture it was that he used.

DR. LAIDLAW: The preparation that I have always used has been the tincture made up after the Rademacher formula, which is the acetate of copper made from acetate of lead and sulphate of copper, which are mixed together and allowed to digest, and chemically manipulated, with the result of a solution of acetate of copper of seven grains to the ounce of water and alcohol. That will be published in the Transactions. I did not think it necessary to read the

formula to you. Whether the ordinary acetate of copper dissolved in water and alcohol, seven grains to the ounce, will do, I do not know. Of that solution I gave ten to thirty drops, which represents a dosage of one-fourth to one-half grain of the acetate of copper. I am sorry Dr. Hamlin has gone out. I just told him I was going to take his head off. He said he was sorry he could not be here to see it done. (Laughter.) I am afraid the authorities are against him on the condition of fœtal labor. The doctor rather explained all cases of tardy fœtal pains by mechanical difficulties. I have thought of that point, and went over the authorities to see whether they were in harmony with me in recognizing such a thing as feeble uterine action independent of mechanical obstruction, and I found that practically all of them do recognize such a state, and in fact it is discussed at great length by Playfair. Now, this is the question that presents itself. We know that the majority of labors will come along all right if we let them alone. We know that the cases for obstetric interference, considering the thousands of children that are born every day, are rare. Yet we know that labor is apt to be a very tedious affair. It was, perhaps, my fortune when I first started out to meet one tedious labor after another. Other doctors had labors finished in five or six hours, and mine would last from fourteen hours to a day,—that I have been kept dancing around there waiting for things to progress. That there was in those cases mechanical interference is possible, that there was a delayed flexion is possible; but it was such a mechanical interference as the forces of the body were able to overcome, that is, if you gave them time enough. Now, I have not the slightest doubt, in these cases in which I used the acetate of copper, which proved to be normal presentations, that if I had waited long enough the uterus would have contracted down and we would have had that baby just a little later. And yet I believe in all the safe ways of hastening labor, for the saving not only of the time of the physician, but the strength of the mother, and on the proof of Simpson's dissertation that fœtal and maternal mortality is in direct proportion to the duration of labor, irrespective of the conditions. So I think it is wise to use something to hasten labor if we can do it safely; and it is on just such grounds that obstetricians use forceps. I think we will have to take for granted that uterine feebleness exists aside from the question of mechanical difficulty. It is such that the unaided forces of the uterus can correct if the pains are strong enough. Now, that is what a drug will do. It will not turn the baby around. I do not believe a drug can twist a child's head. But I believe where we have a mechanical condition, but one which the uterus can handle, if that uterus is strong enough, that there is the point where we should use our drug. Both Dr. Hamlin and Dr. Danforth are in perfect accord with me in that position, because they use drugs in delayed labor. They select gelsemium and causticum and cali carb., which I have heard Dr. Allen lecture on so often, and which has disappointed me just about as often, I am afraid. It is only on the failure of the modern medica-

tion that they resort to interference, and that is my plan; except that in addition to the drugs which they use, I have found that acetate of copper is a helpful drug. Perhaps the doctors did not mean to be as antagonistic as they appeared, and I didn't want you to think that it constituted a sitting down on the use of drugs as an oxytocic in labor. We all use drugs in that condition, and we all recognize by the condition of the mother and the condition of the child when it is time to interfere mechanically; and I simply add to our known drugs this rather unknown drug from antiquity, the acetate of copper, which I believe to be perfectly safe.

DR. B. G. CLARK, of New York: Have you used the homœopathic preparation?

DR. LAIDLAW: No. I have found cuprum recommended in Leavitt for delayed labor with copper symptoms, but I have not used it in potency only in material doses. That, I think, covers the point, that this is not a matter for disguising the lack of skill of the obstetrician. I am afraid too many of us are that way, apt to resort to a drug when we require mechanical or technical knowledge, in order to help us over a difficulty. I do not advocate a man sitting down, looking in his book and giving a medicine there recommended while his patient is dying or going into that state of exhaustion which a too prolonged labor will produce. I do not advocate that a bit. But in addition to our ordinary remedies, let us use this, which has seemed to be successful in these six instances. Let us give it a fair trial, and perhaps we will have added to our resources something of merit.

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## AN OBSTETRICAL ANOMALY.

B. WILLIAMSON,
FRIENDSHIP.

*Mr. President and Members of the Society:* On the 12th of September, 1901, I was called to attend a case in confinement. Arriving late I found one fine, well-developed female child of eight pounds, also a mass of developed tissue covered with clean, strong skin, hardly resembling anything, about five pounds in weight. At one extremity of this body are two irregular prolongations, upon one is a partly developed foot with three toes, each bearing a nail. In the other attempt there is much less similarity to leg or foot. Above these was found a tiny protrusion reminding one of a scrotum or perhaps nipple; then the umbilicus, from which comes a short, small cord, broken off at birth. On the dorsum is a triangular patch, identical to that of a cicatrized burn of an inch and one-half diameter. There is no attempt at shoulders or arms, and

in place of a head, only corrugations not unlike what might be found after healing, if the head had been removed by the ecraseur, except there is found a small opening into a canal. There seems to be a well-formed, bony skeleton for the trunk, covered with good flesh and integument, and both abdominal and thoracic cavities, containing intestines, kidneys, etc., diaphragm and lung tissues. (Careful dissection was not done; specimen in evidence.) The grandfather of it preceded me in possession of the specimen, and the heroic slashes are by his jack-knife, yet served to show the anatomical construction and expose the viscera.

Both the natural child and the specimen were attached to the same placenta, which was monstrous, and both were contained in a common sack, separated by a firm septum, and this sack completely adherent to the dorsum of the placenta, and both born by a single pain.

History: Parents, American; father, aged 52; laborer, and somewhat dissipated. Mother, age 24; large and well developed, and in perfect health and vigor. Third confinement in three and one-half years; all other labors and children normal. Term of gestation said to be ten months. Conception occurring in November, 1900, until March all seemed right when the mother received a terrifying shock. Near her home was a man of whom she justly stood in fear, who was killed by the cars, and her husband witnessing the mangled body, which lay twisted, and headless, rushed home and described the scene, and appearance of the body, with the result of making a most profound and lasting impression on her, causing an illness from which she felt unpleasant until completed term, many times declaring "something was wrong." She could feel life, yet also a constant sense of weight, and cold, dead feeling, of a dragging character. Mother and child at this time were in excellent health.

The query of the writer is, was this result caused by mental emotion from the shock from this story of the headless body, and so directed to the destruction of the head of the fœtus, or was it co-incidental and one child suffered arrested development, both being supported from a common placenta, which was insufficient to sustain both to full term?

# REPORT

OF THE

## BUREAU OF PUBLIC HEALTH.

"Dangers of Climates and Health Resorts," - - BUSHROD W. JAMES.
"Koch's New Theory of Bovine Infection in Tuberculosis," WM. H. VAN DEN BURG.

## DANGERS OF CLIMATES AND HEALTH RESORTS.

DR. BUSHROD WASHINGTON JAMES,
PHILADELPHIA, PA.

Much has been written with regard to the benefits to be derived by the invalid in special climates and in particular localities to which the term "health resorts" has been given by the medical profession, by invalids, and by those who desire to avoid becoming ill.

"Health stations," as they are now called, have benefits in common which every student of climatology recognizes as essential, such as the dryness of the soil, the purity of the atmosphere, the good quality of the drinking water supply, together with the absence of malarial atmosphere in the immediate proximity to the resort, and these are well known. The ordinary hygienic surroundings of a residence anywhere must, of course, be thoroughly carried out in any special situation established for the prevention of disease or the benefit of the sick.

But in this paper we desire to point out two or three of the most common dangers known by the sanitarium to exist, but too often overlooked. It is not infrequently the case that in certain peculiar temperaments individuals will be found to suffer in the higher altitudes and in mountainous regions, and such people will often be compelled to take up a permanent residence in some situation where they can have the benefit of ocean air with its invigorating atmosphere as well as its benign influence, especially in catarrhal cases that are aggravated by a residence in a mountainous or hilly region of country, and I have met with several invalids who have been

injured by living at a home along the seashore and were only helped by a long residence in a higher altitude and with mountainous climatic conditions.

A change of locality is here evidently essential in both cases, as it is evident such individuals will not only be constant sufferers but will eventually assume a critical condition and shorten their days if they continue to live in the unsuitable climate.

The first danger to name, then, is the unsuitableness of the climate and its injurious effect upon certain persons or temperaments; the second danger is not so much the resort itself as the injudicious and improper selection of locality by the physician and the sending of cases to an unsuitable place, so that it seems essential that a climate and "resort" should both be prescribed for the sick, as well as any individual medicinal remedy, for if the situation be not suitable the case may become aggravated and life shortened rather than prolonged by a continued abiding in such unfavorable location. For instance, in pulmonary cases with tubercular disease those who are subject to hæmorrhages and to attacks of nervous prostration should be sent to a cooler, bracing atmosphere, and usually to a situation of considerable altitude above the sea and not to the moist, relaxing and warm atmosphere of the sea coast. Such cases do better in the foot-hill regions of the Blue Ridge, Southern Alleghany, Rocky or Sierra Nevada ranges of mountains, while phthisis cases that have not had hæmorrhages but need an even temperature with freedom from high winds and a sudden change of temperature will usually find less danger by going immediately to a warm, dry, even-tempered climate at once and not experiment with the danger which would result from this mistake and the further danger which would result in the wrong selection of the place which is to be their future health resort.

A third danger not generally thought of by the medical man in sending his cases away from home and the naming of a hotel or a location, is that possibly it may be a town or village which has a reputation both in the public mind as well as in the professional, and yet the accumulation in one place or hotel of a large number of phthisis cases renders such objectionable to those who are not sick, they disturb each other by their coughing and expectorating at night and thereby disturbing each other's sleep and further preventing the much-needed rest which they all require; at the same time by their constant expectorating they make the hotel an unsanitary place for the healthy by depositing tubercular germs all about the building.

To avoid this danger we have now being established in many parts of our country, sanitariums for the treatment of tubercular cases, and it will not be long before hotel keepers will decline to take cases that disturb their other guests, and all these phthisis cases will, as they should be, be sent to such a special sanitarium rather than to any locality or hotel where they are liable to injure and disturb those who are there strictly for health purposes.

Our profession should gladly welcome this increasing tendency and encourage it over the entire country, as proper precaution can there be taken and suitable surroundings afforded the sufferers, that will take away the danger which their presence at a hotel might cause. Fourth, disturbed sleep and quiet, and overtax of the nervous system.

A loss of rest, such as the many noises of fashionable hotel life produce in the banging of doors, the loud laughter and loud conversation in the corridors and hallways, the romping of children in the hallways and rooms and other disturbing annoyances produced by unthinking guests who have little regard for others. These aggravating and unjust disturbances of those who have retired at an earlier hour, and who may be fatigued or nervous or sick and who are entitled to the same protection at the hands of the host, who conducts the hotel, that others receive. One guest should not needlessly awaken another and produce needless insomnia in the latter.

We frequently see, however, a so-called "health resort" made dangerous and injurious not only to the invalid but also to those who are seeking rest and recreation at a miscalled quiet health station Then again, under this head would come the early morning noises of the hotel help in the corridors or about the culinary department of the building which should be maintained in as perfect a state of quiet as possible. The "banging" of doors, the opening of shutters with much force and a loud "bang", the raising or lowering of window-sash with squeaky pulley-wheel that two drops of oil would stop, all of which could easily be avoided by even a very slight amount of care on the part of the employees of the hotel, but the same want of comfort in this direction is permitted by the host in disturbing his guests as he permits to be carried on by noisy and careless inmates. The sweeping of hallways and pushing of chairs in the halls or overhead, or near sleeping rooms comes within these disturbances.

Of course much of this may be avoided by the choice of the hotel and resort with its reputation for quietness or unnecessary noise. People with quiet tastes and needing an undisturbed rest will go to places where it is known that a rigid set of rules are enforced for the general comfort of the entire population of the hotel, and those who are not seeking health but are simply looking forward to the enjoyment of a giddy and boisterous life will select a noisy house where there is no regard paid to the general comfort of their friends and guests who have chosen to receive their hospitality.

Fifth. Improper drainage, incorrect ventilation, impure water for drinking and culinary purposes and unsuitable food are among the many dangers which are readily known to every one who has any idea of correct hygienic and sanitary surroundings. The proper drainage of the entire building is essential; also its proper ventilation both for stormy as well as mild, clear weather; for guests are frequently shut in by heavy rain and wind storms and the hotel air becomes vitiated. Ill health should not be engendered in those who

may seek quarters in a hostelry which is advertised to be a "health resort."

In order to obtain the most healthy conditions and situation in which to live it will be quite essential for the invalid to obtain the full benefit of a proper climate residence, such a one as will be spring-like and cool in the debilitating summer months as well as mild in the rigorous and severe winter season and invalids should go further South as the season becomes more severe and beyond the very changeable and rugged climate of the Temperate Zone.

There are other dangers which might be referred to in regard to location and climate which the judicious prescriber of a health station or invalid resort or special climate will point out and he will name the ones which he desires his patient to avoid in going to a particular location or hotel.

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# KOCH'S NEW THEORY OF BOVINE INFECTION IN TUBERCULOSIS.

WM. H. VAN DEN BURG, M. D.,
NEW YORK.

The utterances of Dr. Koch at the recent Tuberculosis Congress in London make it necessary for us at this time to examine anew the evidence at our command relating to the methods of transmission of this dread disease.

In my paper last autumn, before this Society, on the subject of the Prevention of Tuberculosis, I stated what seemed to me at that time the conclusions to be drawn from the then existing knowledge on the subject.

That paper said, in substance, that the principal means of infection were through the inhalation or ingestion of expectorated and dried tuberculous material, and through the use of infected meat and milk.

At that time I also urged the general dissemination of this knowledge among the laity, in order to arouse them to a sense of their danger, and thus cause them to adopt the necessary measures to eradicate these sources of infection. This public education I regarded and still consider one of the chief forces by which this scourge may be wiped out.

In the light of the best accepted knowledge then available, I considered an elimination of infected meat and milk from the food supply of susceptible individuals an important means of preventing the infection.

Let us now carefully examine some of the new evidence on this phase of the subject presented at the recent Congress in London

by Prof. Koch of Berlin, who is justly regarded as the greatest living authority on this subject. As I understand him, Prof. Koch bases his conclusions upon three propositions:

(1.) The bacilli in bovine tuberculosis are more virulent for cattle and other animals than are human tubercle bacilli.

(2.) That this difference is so marked and so constant that it may be relied upon as a means of distinguishing the one from the other.

(3.) That if bovine bacilli are capable of infecting human beings, there are very many opportunities for such infection through the general consumption of tuberculous milk. And if such infection took place, records of autopsies would show a large number of cases in which primary lesions would be in the intestine. But post-mortem examination of human beings by himself and at the Charité Hospital at Berlin and at the Emperor Frederick Hospital for Children in the same city, show primary intestinal tuberculosis to be very rare. Therefore, the conclusion that the human subject is immune, or so slightly susceptible to bovine tuberculosis that it is not necessary to take any steps to guard against such infection.

The first and second propositions bespeak very little attention at this time as they contain nothing in addition to the theories advanced by Theobald Smith, an American investigator and scientist who, in 1898, detailed a number of experiments showing marked differences in the bacilli of bovine and human tuberculosis. These differences were sufficient to warrant the belief that the processes were distinct though possibly allied.

Other investigators, such as Dinwiddie, Frothingham, Ripp, and more recently Ravenal, whose extensive experiments were made at the laboratory of State Live Stock Sanitary Board of Pennsylvania, have arrived at similar conclusions.

Since all the experimenters agree that the bovine bacilli are more virulent for the animals experimented upon than the bacilli obtained from human sources, might it not be inferred, in the absence of positive proof to the contrary, that they might also infect human beings? Especially is this supposition warranted when we understand that by purely cultural methods Fischel and F. Hueppe have changed avian tuberculosis into mammalian, and vice versa, so that purely mammalian tuberculosis took effect on fowls and avian on mammals.

Nocard has also reported trua avian tuberculosis in the horse and monkey. To be sure these are but rare instances that have been isolated. But are they not enough to show that while the bacilli differ in form, infection is possible from one species to the other?

In the third proposition lies the pith of Koch's recent utterances. And if his conclusions be correct we have great reason to rejoice that one dreaded means of infection has been removed, and that our attention can safely be concentrated upon preventing the bacilli from entering the system by means of inhalation.

But it seems to me that Koch, in drawing his conclusions from

certain experiments, has overlooked some important evidence. For he distinctly says that on swine which were fed with tuberculous sputum, the only lesions that were found were in the lymphatic glands of the neck.

Now, if in animals fed on tuberculous material, the primary and sole lesions appear in the lymphatic glands of the neck, is it not supposable that in children fed on tuberculous material that the primary lesions may appear elsewhere than in the intestine? There seems also to be a great difference of opinion among authorities as to the frequency of primary intestinal tuberculosis. Koch says, in his paper, that among cases of tuberculosis examined after death he can remember having seen only two cases where the intestine was primarily involved. That but ten cases have occurred among the great amount of material at the Charité in the last five years. That Baginsky, among 933 cases of tuberculosis in children never found tuberculosis of the intestine without simultaneous disease of the lungs and bronchial glands. That Bidert, among 3,104 post-mortem examinations of tuberculous children, observed only sixteen cases of primary involvement of the intestine. Also that he could cite from the literature many more statistics of the kind, showing primary tuberculosis of the intestine, especially among children, to be a comparatively rare disease.

Upon the other hand Dr. G. F. Still, of the Hospital for Sick Children, Great Ormond Street, London, concluded that in 29.1% of the cases of tuberculosis in children, the primary infection appeared to have taken place through the intestine.

Dr. Shennan, in the Royal Hospital for Sick Children in Edinburgh, reported 28.1% of his cases of tuberculosis were due to intestinal infection.

It will be observed that Dr. Shennan's and Dr. Still's percentages are very nearly identical and present quite a different showing from those given by Dr. Koch.

Following Dr. Still's cases further, he reports 769 consecutive necropsies of children under 12 years of age, of which 269 showed tuberculous lesions. Of these 117, or 43.5%, were in children under two years of age, while in the first three years of life 56.6% or more than one-half of the total number occurred. Dr. Still believes from his study of the lesions in these cases that in 153, or 56.8%, the respiratory tract was the channel of infection, while in sixty-three, or 23.4% the alimentary canal was responsible, the remaining fifty-three cases being undetermined.

Entering another country we find Wiederhofer, of Vienna, gives an analysis of 415 cases of tuberculosis in children, showing among them 101 with an involvement of the intestine. Of these 42.2% were between the ages of two and five years, or during the period when milk is almost the only article of food.

If we accept these latter figures, and there is no reason to doubt their accuracy, we are forced to the conclusion that outside of Berlin, intestinal tuberculosis in children is anything but a rare disease.

We have in this country direct evidence that occasionally, at least, human beings acquire tuberculosis directly from cattle. Dr. Ravenal reports three cases in which the infecting organism was known positively to be of bovine origin. Tscherning, Pfeiffer and Hartzell each report similar cases, where there can be little or no doubt that the infection was derived from cattle, two of the cases ending fatally after about a year.

These cases, I think, permit us to deny, with authority, that human beings are immune to bovine tuberculosis.

Dr. Ravenal, bacteriologist to the State Live Stock Sanitary Board, of Pennsylvania, after exhaustive experiments with both human and bovine tubercle bacilli concludes "That it is a fair assumption from the evidence at hand and in the absence of evidence to the contrary that the bovine tubercle bacillus has a high degree of pathogenic power for man, as well as the lower animals, which is especially manifested in the early years of life."

In the light of the facts here submitted, I consider it exceedingly unfortunate that Prof. Koch allowed the public press to obtain and publish in the most sensational manner his recent sweeping conclusions. For in his utterances he asks us to overthrow at once the accumulated belief of eighteen years.

At present it seems to me that the weight of evidence is against Koch and that we should discard none of the measures which have so slowly been put into operation to prevent the spread of bovine as well as of human tuberculosis.

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## DISCUSSION.

DR. FAUST: *Mr. Chairman,* I should like to relate an experience which occurred before I took my degree in medicine. My father was particularly interested in veterinary surgery and in bovine tuberculosis. As a lad I can remember going with him and assisting him at autopsies on cattle. I remember distinctly, during the year preceding my entering college, accompanying him to a farm of a gentleman who resided in New York. The exact place and the name of the gentleman I have now forgotten. We there performed an autopsy on a Jersey cow. This cow had been tested previously by the tubercular test and had been condemned. The autopsy was duly performed. The animal was without doubt afflicted with tuberculosis. Both lungs were affected, and the retro-pharyngeal glands were caseous, one of them being partly calcareous, as I remember it. About six months later the child of the gentleman who had owned the cow was taken with meningitis. In about nine or ten days it died, from unmistakable tubercular meningitis. The coachman, who had been drinking the milk of this cow, I afterward learned through father, had been afflicted with tuberculosis. His family history was particularly good, as was that of the parents of the child that died.

Beside, there were also a cat and a dog on this farm, which had drank the milk of this cow, and had also been affected with tuberculosis. It seemed to me to be unmistakable that this case, particularly of the tubercular meningitis, had been directly caused by the use of this tuberculous milk. By the advice of a physician this child had been fed exclusively on the milk of this one Jersey cow. That is one case in particular that just comes to my mind where it is pretty hard to escape the evidence that animal tuberculosis is communicable to man.

DR. VAN DEN BERG: I think there is very little more to say in the way of discussion on the subject, Mr. Chairman. There seems to be a pretty general concensus of opinion on this side of the water at all events, and in England, so far as I can learn from reading, that Prof. Koch has been a little bit unwise in announcing his conclusions with possibly a lack of sufficient evidence to prove them; and the object of this paper was simply to bring before the Society the fact that while Koch is a great authority on the subject, it is possible even for great authorities to make mistakes, or to draw conclusions from incomplete evidence; and it is my desire at all events that none of the measures which have heretofore been employed for preventing the spread of tuberculosis from cattle to man, or from cattle to cattle, shall be relaxed; and that is about all there is to say on the subject.

# APPENDIX.

Necrologist's Report.....W. S. GARNSEY
Obituaries of—
HARRIET BARKELOO.
ANDREW R. WRIGHT.
CLARENCE E. BEEBE.
WILLIAM TOWNSEND LAIRD.
RICHARD K. VALENTINE.
F. W. SPOOR.
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Biographical Sketch of PRESIDENT GREENLEAF.
Constitution and By-Laws.
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# Necrologist's Report.

## WILLIAM TOWNSEND LAIRD, M. D.

Dr. Laird was born in Stittsville, Oneida Co., N. Y., August 2, 1846. He attended private and public schools at Stittsville and Holland Patent, and in 1862 entered Whitestown Seminary. He entered Hamilton College in 1864. Here he was awarded the Curran gold medal in classics, was the poet on class day, and valedictorian on graduating in 1868. He taught for a while in the Clinton Grammar School, but resigned at the end of the term to study medicine with Dr. M. M. Gardner, of Utica. He attended the Hahnemann Medical College of Philadelphia, and the New York Homœopathic Medical College, graduating from the latter February 29, 1872. For a thesis on "Tumors" he was awarded the Helmuth medal, and the

paper constituted the chapter on that subject in Helmuth's surgery. He stood second in his class, and for a time held the position of assistant professor of chemistry under Dr. Charles Avery.

In April, 1872, he associated himself with Dr. J. V. Daggert, of Watertown, and later with Dr. S. C. Knickerbocker.

In June, 1878, he married Miss Minnie Raplee, of Watertown, and in June, 1880, removed to Augusta, Maine, where he continued in practice until July, 1882, when he removed to Utica, N. Y. While in Augusta he was elected president of the State Homœopathic Medical Society and delivered an address on "The Relation of Pathology to Therapeutics", which was warmly commended by one wing of the profession and severely criticised by the other. He was a frequent contributor to medical literature, especially in the line of materia medica and therapeutics. Probably his most notable and widely-known contribution was the little classic on "Diarrhœa" by "Bell and Laird." His memory was remarkable, especially for materia medica, which made him a most accurate prescriber and strict homœopath.

In January, 1883, Dr. Laird returned to Watertown, N. Y., which was ever afterward his home. Here he died October 7, 1899, after many months of suffering from cancer of the cheek.

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## RICHARD K. VALENTINE, M. D.

Dr. Richard K. Valentine died March 22, 1901, at his residence, 190 Lincoln Place, Brooklyn, N. Y. He was born in Brooklyn in 1855 and was the second son of Samuel T. and Anna K. Valentine. He graduated from the New York Homœopathic Medical College in 1875 and after spending two years abroad settled in Brooklyn. He was demonstrator of anatomy in his mother college two or more years. He was influential in the Kings County Homœopathic Medical Society and had been its president. Was a member of the Unanimous Club, a society composed of physicians; also of the Montauk, the Marine and Field Clubs, of Brooklyn.

He is survived by a widow and one son, Richard K. Valentine, Jr., now about 13 years old.

He had been ill several days with LaGrippe and had been mentally depressed. Although closely watched by trained nurses he obtained a lance and succeeded in making a wound in his neck, from which he quickly died. Thus ended the life of one who apparently had very much to live for and from whom the world had a right to expect much.

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## F. W. SPOOR, M. D.

Dr. F. W. Spoor was born February 21, 1859, in Hartland, Niagara Co., N. Y. He received his education in the Normal School

at Brockport, N. Y., after which he graduated from the New York Homœopathic Medical College in 1884. He first located at North Creek, N. Y., where he soon acquired a flourishing practice, but it was such a hard field that after six years he sought more agreeable work at North Granville, N. Y., where he settled in 1890. Here he practiced very successfully for eight years, when his health failed and he removed to Lowville, N. Y., where he died August 6th, 1898.

He was married in 1889 to Miss Anna L. Osgood, of Brockport, N. Y., who with two sons, Gordon F. and Lowell D., still survive him. His life was one of activity and usefulness and many mourn his early death.

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## HARRIET BARKELOO, M. D.

By JOHN L. MOFFAT, M. D.

Dr. Harriet Barkeloo was graduated by the New York Medical College and Hospital for Women in 1880, the next day opened an office in her old home, 915 Third Avenue, then the shore of Gowanus Bay, and soon acquired a large practice in that part of her native city.

In the year of her graduation she became a member of the Kings County Society, and nine years later of our State Society.

Dr. M. Belle Brown writes: "She was self-reliant, far above the average doctor, always cheerful and hopeful, inspiring her patients by the buoyancy of her spirits. She was an educated woman with refined tastes, loyal to her friends and faithful to the duties she assumed."

Dr. Hasbrouck "Saw her during her last illness first on the fourth of January, when she told me that she had been ill with pneumonia—but not in bed, having been out of doors within two days—for two weeks past. She did not at that time seem to be very ill. I suggested that she take Bryonia 6th and 'be good to herself.' It seemed then to me that a few days of care would be sufficient to get her around again; but I was recalled on the next day but one, and found her with marked cardiac asthenia, from which she could not be made to rally by the treatment given during the five visits made in the next two days, she dying on January 9th of heart failure."

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## ANDREW R. WRIGHT, M. D.

By JOS. T. COOK, M. D.

Dr. Andrew R. Wright died in Chicago on February 24, 1900. He was 75 years of age, and engaged in the active practice of his profession up to two days before his death. He went as he had always

A. R. WRIGHT, M. D.

wished to go—quickly and before the time came when he would have to give up his work and sit idly by, waiting.

Born in Orange Co., N. Y., his early years were those of the average country boy, full of toil and empty of encouragement. He succeeded in getting an education, however, and was graduated from the New York State Normal School in 1848 and taught in the Albany Male Academy and in the public school of Elmira until 1852.

In that year he entered the office of Dr. N. H. Warner, of Buffalo, as a student, and attended lectures at the Buffalo Medical College.

Two years later, his health failing, he was ordered by Dr. Warner to take a sea voyage. With but little money he went to New York and after some weeks of waiting, embarked on a sailing vessel for China. Before leaving he purchased a large case of homœopathic remedies, and by acting as ship's surgeon on the voyage was given passage for half fare. He arrived in China with but fifteen dollars, his medicines and a large stock of courage.

Soon he made the acquaintance of the head of a large firm of exporters, by whose influence he obtained the position of surgeon on one of H. B. M.'s mail steamships of the P. and O. line. For two years he cruised through Oriental waters, after which, his health being restored, he went to Paris for study under those pioneers of homœopathy, Tessier, Teste and others.

Returning to the United States he graduated from the Western Medical College of Cleveland in 1858 and went to Elmira to practice, but remained there but one year, when he returned to Buffalo and became associated with Drs. Warner and Kenyon.

In 1860, Dr. Warner having died and Dr. Kenyon obliged on account of ill health to temporarily give up active work, Dr. Wright was left with a large practice, which he held up to the time of his death.

He was a valued member of many medical societies, and served as President of the New York State Society in 1880, of the Western New York Homœopathic Medical Society in 1889 and of the American Institute of Homœopathy in 1898. For some years prior to his death he served as consulting physician to the Buffalo Homœopathic Hospital.

No one who knew Dr. Wright could fail to appreciate and be touched by his sterling honesty, his extreme modesty and his excellent skill and judgment. Generous to a fault, he was ever ready to help those that needed help, to pardon the short-comings of others, but to hold himself to a strict accountability.

His death was sincerely mourned by the medical profession and by hundreds who knew him as the kindly, skillful physician and loyal friend.

## CLARENCE EDWIN BEEBE, M. D.

By J. B. Garrison, M. D.

Dr. Clarence Edwin Beebe was born on June 4th, 1849, and died on March 1st, 1900. He was educated at Flushing Institute, where he prepared for Yale College, which he entered at the age of 16, with the class of 1871. He was a "Phi Beta Kappa" man and also a "Spoon Man" (only nine men in a class are chosen), a member of the "Psi Upsilon" Society and a member of the Senior Society of "Scroll and Key." He entered the Medical College of the University of New York with the class of '74, but did the work in two years and graduated with the class of '73. He was valedictorian of his class. He took up the study of homœopathy at once and ever practiced after that faith. He soon devoted himself to the practice of the specialty of diseases of nose and throat and soon had a large and wealthy clientelle. He became a member of the Homœopathic Medical Society of the County of New York and was its president for one year. Also was member of the Homœopathic Medical Society of the State of New York, American Institute of Homœopathy, New York Homœopathic Mat. Med. Society, New York Medical Club, Jahr Club, and when he died was Emeritus Professor Laryngology and Rhinology New York Homœopathic Medical College and Hospital, Consulting Surgeon New York Homœopathic Medical College and Hospital and New York Ophthalmic Hospital. In 1874 he married Miss Maria Louisa White, and four children were the result of this union, three boys and one girl. Two of these are living, both boys. He was a deacon and later an elder in the Madison Square Presbyterian Church, interested in every forward movement for righteousness. He was for a number of years a loyal member of the Seventh Regiment, National Guard, State of New York, and after his resignation, which was made necessary on account of illness in his family, he became a member of the "Veterans of the Seventh Regiment."

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## JESSIE SHEPARD, M. D.

By Joseph T. Cook, M. D.

Dr. Jessie Shepard, of Buffalo, the grand-daughter of a physician, was born in this city, in the year 1861. She received her early education in one of our district public schools, and in the Central High School. Choosing the profession of a physician she began her medical studies in the office of the late Dr. A. C. Hoxsie. She attended one year the Homœopathic Hospital College in Cleveland, Ohio, and later the Boston University, Medical Department, where she was graduated in 1888. She served one year as house surgeon in the Massachusetts Homœopathic Hospital, and for some time afterwards practiced in the office of Dr. Joseph T. Cook, of this city. Some few years ago she went to Vienna, Austria, and spent a year in the

General Hospital there, afterwards returning to Buffalo to continue her work.

Dr. Shepard's death on August 24th last, following an operation for appendicitis, was a great shock to a large number of friends. Possessing ability, industry and fondness for her work, she had also much sympathy and tenderness, and was a woman that endeared herself to those who came in contact with her.

The professional associates of Dr. Jessie Shepard learned with most profound regret of her sudden and untimely death. Dr. Shepard was one whom to know was to admire, and the closer the acquaintance, the deeper the respect and admiration engendered by her quiet and unostentatious manner, her cordial good fellowship and her genuine ability. Strong, without losing her womanly tenderness, active and energetic, without being aggressive, she inspired with confidence and esteem all with whom she came in contact in her professional as well as in her personal relations of life. The question of physical weariness or tax on her strength never hindered her responding with cheerful alacrity to any call for her professional aid, whether that call was from the homes of her more wealthy and influential patrons, or from some poor sufferer from whom the only recompense to be looked for was the thankful recognition of her ability and assistance. The conscientious thoroughness and the careful skill with which she accomplished any duty demanding her attention were among her more marked characteristics.

Dr. Shepard ever strove to keep entirely abreast of the times in all that pertained to the scientific and most advanced branches of her work. She was a close and intelligent student, possessing also the tact and ability to utilize to the fullest extent the results of her study and investigation.

Her associates in the hospital, in the home and in medical societies will miss her hearty co-operation, her ready, but always kindly criticism, and her valuable aid in lines in which her personality made her particularly efficient, and where her loss will be most deeply felt.

Dr. Shepard had for some years held an appointment as an obstetrician upon the staff of the Buffalo Homœopathic Hospital, where she had performed most excellent and painstaking work. She had recently been chosen, after much consideration, to serve upon the medical committee in charge of the Training School for Nurses, attached to the same hospital. This latter appointment was a great compliment to her and a special evidence of the high position which she had made for herself in the city and among the physicians of the hospital staff.

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## OREN G. HUNT, M. D.

Taken from *The Chironian.*

Dr. Oren G. Hunt, '86, who died at his residence, 134 East 19th Street, on Christmas Eve, 1900, was born in Nunda, N. Y., on his father's farm, December 21, 1857. He early evinced a desire and taste for the practice of medicine and as a boy laid plans to this

end. His preparatory education was obtained at the Nunda Academy, from which institution he was graduated. He immediately began to teach school during the winter months, and by working on the farm during the summer he acquired the means necessary to enable him to enter the New York Homœopathic Medical College in 1883. Graduating with honorable mention from college, in 1886, he entered the competition examination for resident physician to the College Dispensary and was successful in securing the appointment to the position, which he held for a second year at the request of the trustees. He resigned this position in 1888 to accept the Clinic Department of Diseases of the Heart and Lungs in the dispensary and also acting as assistant to the chair of those diseases in the college, having previously pursued special courses in the eye and ear and nose, throat and lungs. During his college days, Dr. Hunt was one of the editors of *The Chironian*, a member of the college quartette, and among other positions than those already mentioned, he was for some time assistant surgeon to the New York Ophthalmic Hospital and, later, consulting surgeon to that institution and since 1888 a member of its executive committee. Dr. Hunt was a member of the State Homœopathic Medical Society, a vice-president of the New York County Homœopathic Medical Association and secretary and treasurer of the Medico-Social Club and was a writer of many important papers in his special branches. Dr. Hunt had obtained marked success and recognition in diseases of the nose, throat, lungs and heart and the same acute perception and attention to business and detail which was noticed in his boyhood days was a prominent factor in this.

Always a student, extremely thorough and conscientious, possessing unusual skill and a most charitable and kindly nature, the medical fraternity, as well as his patients, has experienced a serious loss. Dr. Hunt was sick but a few hours and died from an attack of hæmorrhage of the stomach, evidently induced by overwork. He was unmarried and is survived by his parents and four brothers, one of whom, A. B. Hunt, Ph. D., of Bloomfield, N. J., was with him during his sickness and death.

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## JOHN D. HEINEMANN, M. D.

By DeWitt G. Wilcox, M. D.

Dr. John D. Heinemann, of Buffalo, was born December 4th, 1850, at St. Johnsburg, N. Y. He attended lectures at the Cleveland Homœopathic Hospital College, where he graduated in 1876. He came to Buffalo immediately after graduation and located at No. 77 East Eagle Street, where he had been in continuous practice up to the time of his death, a period of twenty-five years. In 1879 he married Hulda Sehler, by whom he has had eight children. He is survived by the widow and six children. Dr. Heinemann was a member of the Lutheran Church. He died April 23rd, 1901, due to cardiac dropsy.

# BIOGRAPHICAL SKETCH OF PRESIDENT JOHN T. GREENLEAF.

Dr. John T. Greenleaf comes of Huguenot stock, the common ancestor of the Greenleaf family in the United States having settled in Newbury, Mass., about 1634, and the subsequent generations having been scattered thence, pretty well over the republic. They were prominent in the Revolution and have numbered in their ranks many men of note, clergymen, authors, teachers, physicians and lawyers being largely in excess.

The grandfather of the doctor located in Tioga County, in March, 1817, and the subject of our sketch was born at Owego, N. Y., January 26th, 1847. He was educated at the Owego Academy, and received his degree at the New York Homœopathic Medical College, in the class of '67. He located immediately at Candor, N. Y., and began practice. He moved to Owego in December of the same year, where he has since resided. In 1899 he joined Dr. E. E. Snyder, of Binghamton, in founding Glenmary Home and in 1899 he selected the site and opened the institution known as Oak Hill at Montclair, N. J.

The doctor has been thrice married, his nuptials with Miss Hattie Meeker, of Owego, N. Y., his present wife, having been celebrated October 23rd, 1873. He is a member of the Presbyterian Church and has now closed his thirty-ninth year of service in the choir of that venerable organization.

He has always been interested in educational affairs in his home having served twenty-eight years on the school board of that town and now being secretary and treasurer of the Coburn Free Library Association. Many articles from his pen in the medical journals and the Society Transactions show something of his versatility in this respect. He is also given to rhyming, as many of his medical friends can testify to the witty and bright lines with which he has upon many occasions entertained them. He has published many poems and written much for after-dinner purposes and a number of memorial compositions for Decoration Day.

He is a senior of the American Institute, a member of various local societies, of the American Association for the advancement of Science, of the American Association of Microscopists and is a Son of the Revolution.

# CONSTITUTION AND BY-LAWS.

## CONSTITUTION.

### ARTICLE I.—NAME.

§ 1. In pursuance of Chap. 268, Laws of 1862, by which it was incorporated, this association shall be known as the Homœopathic Medical Society of the State of New York.

§ 2. Its objects shall be the advancement of homœopathic therapeutics and of all other departments of medicine and surgery.

### ARTICLE II.—MEMBERS.*

The Society shall be composed of permanent members, of delegates from homœopathic county societies and corporate institutions or associations of this State, and of such other members as may be chosen in conformity with the By-Laws.

### ARTICLE III.—OFFICERS.

§ 1. The officers of this Society shall be a president, three vice-presidents, a secretary, treasurer, necrologist and twelve censors (three of whom shall be selected from each of the four Censorial Districts of the State), who shall be elected by ballot by a majority of the active members present at each annual meeting.

§ 2. Their term of office shall commence at the close of the meeting at which they are elected, and shall continue for one year, until the adjournment of the next annual meeting, and until their successors are elected.

### ARTICLE IV.—SEAL.

The subjoined, either printed or embossed, shall be the official seal of the Society.

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*This Society "may elect such a number of permanent, delegate or other members as may be provided for by the constitution and by-laws," and is "empowered to regulate and control its own membership." Laws of 1882, Chap. 309.

## ARTICLE V.—MEETINGS.*

§ 1. The annual meeting shall be held each year at Albany, commencing on the second Tuesday in February.

§ 2. A semi-annual meeting may be held at such time and place as the Society shall determine.

§ 3. Special meetings may be called by the Executive Board, or by the President upon the call of ten active members.

## ARTICLE VI.—QUORUM.

Ten active members shall constitute a quorum.

## ARTICLE VII.—AMENDMENTS.

Any article of this constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting.

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*This Society may select the time and place for holding its annual and other Meetings. Laws of 1875, chap. 449.

# BY-LAWS.

## ARTICLE I.—DUTIES AND ELECTION OF OFFICERS.

§ 1. The duties and responsibilities of the president, vice-presidents, secretary, treasurer and necrologist shall be such as are usually incident to these offices.

§ 2. The President shall deliver an address at the annual or semi-annual meeting, appoint standing committees, bureaus and delegates, make appointments to fill vacancies and be ex-officio member of all committees.

§ 3. The Secretary, in addition to his other duties, shall annually edit the Transactions of the Society and the State Directory of Homœopathic Physicians, consulting with the Executive Board when he or they deem it necessary. He shall divide the delegate members into four classes as nearly equal as possible, one of which classes shall go out of office each year.

He shall be paid a salary of two hundred and fifty dollars per annum.

§ 4. The Treasurer shall keep the funds of the Society in a bank or trust company approved by the Executive Board, and the account shall stand in the name of the Society.

Each year he shall furnish a copy of the current issue of the Transactions to each permanent and senior member in good standing, and shall send to each county society not in arrears as many copies as it is entitled to delegates.

At each regular meeting he shall announce the names of such applicants as shall have failed to qualify for membership.

At each annual meeting he shall report the names of such members, institutions and county societies as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote.

He shall turn over to his successor all property of the Society in his charge.

In lieu of salary he shall be reimbursed for his traveling expenses incurred in attending the meetings of the Society.

§ 5. It shall be the duty of the Censors to consider all applications for permanent membership, reporting to the Society at the same or next meeting such as they judge to be properly qualified for election.

Three shall constitute a quorum.

§ 6. Officers shall be voted for together on a ballot to be deposited, by each active member voting, between the hours of twelve and twelve-thirty p. m. on the second day of the annual meeting.

Within one hour after the closing of the poll the tellers shall make report.

In case of failure to elect, another ballot for the office or offices to be filled shall be ordered held at once or at a subsequent session.

The tellers shall receive no ballot unless notified by the Treasurer that the member wishing to vote has paid his or her dues, in evidence of which shall be the list furnished the tellers by the Treasurer or his receipt for the dues in question.

## ARTICLE II.—MEMBERSHIP.

§ 1. By the term "active members" is meant such permanent, delegate and senior members as are in good standing.

§ 2. Any physician desiring Permanent Membership must be of good moral and professional standing, and legally licensed to practice medicine under the laws of this State.

The candidate must sign the following form, properly filled out and indorsed: "I request membership in the Homœopathic Medical Society of the State of New York. I agree, if elected, to pay my dues promptly and regularly to the Society. I promise to return promptly to the Secretary my certificate of membership if and when I resign or am dropped from the Society. I hereby acknowledge that I believe *Similia Similibus Curantur*. I reside at No..... in.....County of.....and am a graduate of.....in the year.....My license to practice is .....dated..... (Signed) (date). The undersigned permanent members indorse the above applicant as worthy of permanent membership in this Society. (Signed).....and.....

After having been favorably reported on by the Censors and accepted by a majority vote of the active members present at a regular meeting, the candidate, upon the payment of five dollars, shall become a permanent member entitled to the rights and privileges of membership, including a certificate of membership.

If the first year's dues be not paid before the regular meeting next succeeding his or her election, such election shall be void and his or her name shall be published each year in a special list in the back of the Transactions.

The first, second, third and fourth paragraphs of this section shall be printed upon the application blanks.

§ 3. Each homœopathic county society in this State is entitled to elect, for a term of four years, as many Delegate Members of this Society as there are assembly districts in that county.

Permanent members shall not be eligible, and every delegate becoming a permanent member shall thereby cease to be a delegate member.

Each incorporated homœopathic institution or association in this State shall be entitled, upon payment of the annual dues, to single delegate representation in this Society, the term of the delegate to be four years.

Delegate members in good standing have all the rights and privileges of permanent membership except the certificate, eligibility to senior membership and election to the presidency.

§ 4. Any permanent member may be elected a Senior Member at an annual meeting, provided that at the time of such election he or she is in good standing and shall have paid dues for twenty years.

Senior members shall be exempt from dues and assessments, and shall be entitled to all rights and privileges of membership.

§ 5. Any physician or surgeon not a resident of this State, who has manifested superior attainments in medicine or one of its collateral sciences, may be elected an Honorary Member at an annual meeting, provided that the nomination, accompanied by reasons for conferring the honor, shall have been made at a previous regular meeting. Not more than three honorary members shall be elected in any one year.

Honorary members may participate in the proceedings of this Society (except that they shall not vote nor be eligible to office) and are requested to contribute papers. They shall be entitled to receive the volumes of Transactions to which they contribute papers.

## ARTICLE III.—DUES.

§ 1. The annual dues shall be three dollars from each permanent member and from each institution or association which appoints a delegate; from each county society there shall be due three dollars per annum for each delegate to which that society is entitled.

§ 2. Each permanent member shall pay a membership fee of five dollars, which shall include the dues for the current year, at the time of his or her election.

§ 3. No member in arrears shall be entitled to the privileges of membership.

Members three years in arrears shall be dropped from the roll, and their names published each year in a special list as having been dropped for non-payment of dues.

## ARTICLE IV.—COMMITTEES AND BUREAUS.

§ 1. The Executive Board, consisting of the president, vice-presidents, secretary and treasurer, shall act as the executive committee of the Society, attending to matters not otherwise provided for, or that may be referred to it.

When necessary it may call a special meeting of the Society, specifying time, place and object.

It shall serve as an advisory committee of publication with discretionary power as to the appearance in the Transactions of any given report or paper.

§ 2. The President-elect shall annually appoint the chairman of the Committee on State Medical Examiners and a chairman, with at least two members, of the Committee on Legislation and of each of the following bureaus: Materia Medica, Clinical Medicine and Pathology, Surgery, Obstetrics, Gynæcology, Pædiatrics, Neurology, Ophthalmology and Otology, Laryngology and Rhinology, and Public Health.

## ARTICLE V.—PAPERS.

§ 1. All papers, communications and reports read before or presented to this Society become thereby its property, and must be at once deposited with the Secretary. They may afterward, by means of copies, be published in medical journals if due credit be given to this Society.

§ 2. No paper nor report shall be received for publication that has previously been either published or presented to another society, or that is in an unfinished condition.

§ 3. Only fifteen minutes shall be allowed for the reading of a paper, ten minutes each for its opening and closing discussion, and five minutes each for other remarks discussing it. This rule may be suspended only by the unanimous consent of those present.

## ARTICLE VI.—STATE MEDICAL EXAMINERS.*

§ 1. This Society shall at each annual meeting, by a majority vote, nominate to the Regents of the University for appointment as State Medical Examiners at least twice as many persons as there are appointments to be made.

§ 2. Each nominee must be a member of this Society in good standing, must have been graduated in course from a reputable medical college, and must have been practicing medicine or surgery under the laws of this State for at least five years immediately prior to the first of July following said nomination.

§ 3. The Secretary shall send to each permanent and delegate member of this Society, a week before the annual meeting the nominations by the Committee on State Medical Examiners of at least three times as many nominees as there are appointments to be made.

Each active member present may, between twelve and twelve-thirty p. m. of the second day of the annual meeting, deposit with two special tellers appointed by the president, a ballot for at least twice as many nominees as there are appointments to be made. Such names as receive a majority of the votes cast shall be presented to the Regents.

In case a sufficient number of names (twice the number of appointments to be made) do not receive a majority vote, the quota shall be filled by a ballot upon names submitted in open nomination.

§ 4. If charges of unprofessional or dishonorable conduct or continued neglect of duty are made against any State Medical Examiner representing this Society, the Society, after considering the matter in Committee of the Whole, may by a majority vote at any regular or special meeting submit the evidence in the case to the Regents and may request the removal of said Examiner.

§ 5. The Committee on State Medical Examiners shall consist of five members, to be elected by ballot at the annual meeting. The

*Laws of New York, 1890, Chap. 507.

chairman shall be appointed from among their number by the president-elect within three weeks. Their term of office shall commence at the close of the meeting at which they are elected and shall continue one year, to the close of the next annual meeting, and until their successors are elected.

## ARTICLE VII.—ORDER OF BUSINESS.

At the meetings of this Society the following shall be the Order of Business, unless otherwise prescribed by the Executive Board or changed by the Society.

Prayer.
Communication from the President.
Appointments:
- Committee on Attendance;
- Committee on President's Address;
- Auditing Committee;
- Tellers.

Minutes of the last meeting.
Report of the Board of Censors.
Elections:
- of Members—Permanent, Senior, Honorary;
- of Officers (at time specified);
- of Nominees as State Medical Examiners (at time specified);
- of Committee on State Medical Examiners.

Reports:
- of Officers;
- of Committees;
- of Bureaus.

Miscellaneous business.

## ARTICLE VIII.—GOVERNMENT.

This Society shall be governed by the Code of Ethics adopted by the American Institute of Homœopathy, and by parliamentary usage as set forth in Roberts' Rules of Order for Deliberative Assemblies.

## ARTICLE IX.—AMENDMENT.

These By-Laws may be amended by a two-thirds vote of the active members present at an annual meeting, provided that written notice shall have been given at a previous regular meeting.

# STANDING RESOLUTIONS.

### DELINQUENT MEMBERS.

*Whereas*, It has been proposed that members dropped for non-payment of dues, asking to be reinstated should have their back dues remitted, and

*Whereas*, It would seem that such action would be prejudicial to the best interests of the Society by encouraging delinquency; therefore

*Resolved*, That the power of re-instatement in such cases be vested in the Executive Board, with the understanding that such leniency shall be exercised only in exceptional cases where unfortunate circumstances seem to render it necessary.

Adopted, Feb. 9, 1892.

### ANNUAL REPORT OF STATE MEDICAL EXAMINERS.

At each annual meeting the chairman of our Board of State Medical Examiners shall make a report to us of the work done by the Board during the year.

Adopted Feb. 14, 1893.

### PAPERS BY TITLE.

*Resolved*, That when the writer of a paper is not in attendance upon the meeting at which it is presented, the said paper shall be read by title. The only exception to be made to this rule shall be when the work of the Society is ahead of the schedule in point of time.

Adopted, Feb. 12, 1895.

### POSTAL NOTICE.

Not more than three nor less than two weeks previous to every regular meeting the Secretary shall send to each member a (postal card) notice of its date and place.

Adopted, Feb. 8, 1898.

## HONORARY MEMBERS.

| | | Elected. |
|---|---|---|
| Allen, Henry C. | 5142 Washington Ave., Chicago, Ill., | 1886 |
| Bartlett, Clarence | Arch St., Philadelphia, Pa., | 1890 |
| Biggar, Hamilton F. | Cleveland, O., | 1887 |
| Blake, J. Gibbs | England, | 1882 |
| Breyfogle, W. L. | New Albany, Ind., | 1881 |
| Budlong, John C. | Providence, R. I., | 1881 |
| Clifton, Arthur C. | 9 Park Parade, Northampton, Eng., | 1888 |
| De Derkey, F. F. | 311 W. 3d St., Los Angeles, Cal., | 1881 |
| Drummond, John | Manchester, Eng., | 1870 |
| Dudgeon, R. E. | 53 Montague Sq., London, W., Eng., | 1867 |
| Duncan, T. C. | 100 State St., Chicago, Ill., | 1869 |
| Edie, John L. | Leavenworth, Kan., | 1870 |
| Emerson, N. W. | 685 Boylston St., Boston, Mass., | 1900 |
| Gallinger, J. H. | Concord, N. H., | 1881 |
| Gilchrist, James G. | 215 College St., Iowa City, Ia., | 1888 |
| Hayward, John W. | 61 Shrewsbury Road, Birkenhead, Cheshire, Eng., | 1882 |
| Heath, Edwin R. | Kansas City, Kan., | 1868 |
| Henderson, William | Edinburgh, Scotland, | 1869 |
| Hirschel, B. | Dresden, Saxony, Germany, | 1871 |
| James, Bushrod W. | Green and 18th Sts., Philadelphia, Pa., | 1868 |
| Jones, Samuel A. | Ann Arbor, Mich., | 1882 |
| Kinne, Theodore Y. | Paterson, N. J., | 1893 |
| Linnell, E. H. | 61 Broadway, Norwich, Conn., | 1891 |
| Madden, H. R. | London, Eng., | 1870 |
| Mandeville, F. B. | Newark, N. J., | 1873 |
| McGeorge, Wallace | 521 Broadway, Camden, N. J., | 1884 |
| Packard, Horace | 470 Commonwealth Ave., Boston, | 1900 |
| Peck, George B. | 865 N. Main St., Providence, R. I., | 1882 |
| Pope, Alfred C. | Grantham, Eng., | 1871 |
| Roth, Mathias | London, Eng., | 1871 |
| Runnels, O. S. | 203 N. Meridian St., Indianapolis, Ind., | 1882 |
| Sanders, John C. | 608 Prospect St., Cleveland, O., | 1865 |
| Shears, G. F. | 3130 Indiana Ave., Chicago, Ill., | 1900 |
| Skinner, Thomas | 6 York Pl., London, W., Eng., | 1878 |
| Sparhawk, George E. E. | Burlington, Vt., | 1875 |
| Van Lennep, W. B. | 1421 Spruce St., Philadelphia, Pa., | 1900 |
| Wesselhoeft, Conrad | 291 Boylston St., Boston, Mass., | 1888 |
| Wilson, David | London, Eng., | 1865 |
| Wood, James C. | 122 Euclid Ave., Cleveland, O., | 1891 |
| Worcester, Samuel | 597 Congress St., Portland, Me., | 1873 |

# OFFICERS, 1850—1900.

| Year. | Presidents | 1st Vice-President. | 2nd Vice-President. | 3rd Vice-President | Secretary. | Treasurer. | Cor. Secretary. |
|---|---|---|---|---|---|---|---|
| 1850. | *Isaac M. Ward, Albany. | *D. Chase. | *R. S. Bryan. | *A. S. Ball. | *Henry D. Paine. | | |
| 1851. | *F. Vanderbergh, New York. | *L. Clary. | *F. Humphreys. | *Geo. W. Lewis. | " | | |
| 1852. | *Lyman Clary, Syracuse. | *Alonzo S. Ball. | *E. L. Coburn. | *D. Chase. | " | | |
| 1853. | *Alonzo S. Ball, New York. | *N. H. Warner. | S. S. Guy. | *L. B. Wells. | " | | |
| 1854. | *Amherst Childs, Waterloo. | *Henry Adams | *Josiah Bowers. | *E. T. Richardson. | " | | |
| 1855. | Samuel S. Guy, Brooklyn. | *M. M. Matthews. | *R. S. Bryan. | *David Springsteed. | " | | |
| 1856. | *M. M. Matthews, Rochester. | *J. M. Quinn. | *Henry Adams. | *L. B. Wells. | " | | |
| 1857. | *R. S. Bryan, Troy. | *A. P. Cook. | *L. B. Wells. | *J. C. Peters. | " | *J. W. Cox. | |
| 1861. | *Ethan A. Potter, Oswego. | *Simeon A. Cook. | A. R. Wright. | *Cornelius Ormes. | Horace M. Paine. | *J. W. Cox. | |
| 1862. | *Jacob Beakley, New York. | *A. R. Wright. | *E. A. Munger. | W. S. Searle. | " | *L. B. Wells. | |
| 1863. | *Henry D. Paine, New York. | *William Wright. | C. W. Boyce. | Asa S. Couch. | " | " | |
| 1864. | *Erastus A. Munger, Waterville. | S. S. Guy. | A. R. Morgan. | " | " | " | |
| 1865. | *Abijah P. Cook, Hudson. | *Benj. F. Cornell. | *Benj. F. Bowers. | *L. M. Kenyon. | " | " | H. B. Fellows. |
| 1866. | *Horatio Robinson, Auburn. | *Lucien B. Wells. | *Wm. B. Stebbins. | *Edgar B. Cole. | " | *J. S. Delavan. | " |
| 1867. | *B. F. Cornell, Moreau Station. | *S. B. Barlow. | William H. Watson. | L. M. Pratt. | H. B. Fellows. | *J. W. Cox. | *E. D. Jones. |
| 1868. | William H. Watson, Utica. | T. F. Allen. | *T. L. Brown. | *D. F. Bishop. | H. M. Paine. | W. S. Searle. | " |
| 1869. | *William Wright, Brooklyn. | E. B. Holmes. | *Henry Minton. | *E. P. K. Smith. | " | " | " |
| 1870. | *Lucien B. Wells, Utica. | *Edwin H. Hurd. | *Ezra P. K. Smith. | T. Franklin Smith. | " | " | " |
| 1871. | *John F. Gray, New York. | T. Franklin Smith. | J. C. Raymond. | *A. W. Holden. | " | *J. F. McKown. | " |
| 1872. | *H. A. Houghton, Keeseville | *Charles Sumner. | H. S. Hutchinson. | G. L. Gifford. | " | Nelson Hunting. | L. M Pratt |
| 1873. | *E. Darwin Jones, Albany. | *D. F. Bishop. | *J. Ralsey White. | R. E. Miller. | *Frank L. Vincent. | Nelson Hunting. | L. M. Pratt. |
| 1874. | *L. M. Kenyon, Buffalo. | *A. E. Sumner. | *S.C.Knickerbocker. | *Henry Sales. | " | *F. L. Vincent. | " |

*Deceased.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1875. | *A. W. Holden, Glens Falls. | E. M. Kellogg. | *H. V. Miller. | R. S. Bishop. | *F. L. Vincent. | *E. D. Jones. | L. M. Pratt. |
| 1876. | T. F. Allen, New York. | *A. R. Wright. | William Gulick. | Henry R. Stiles. | Alfred K. Hills. | *F. L. Vincent. | " |
| 1877. | Egbert Guernsey, New York. | William Gulick. | Henry R. Stiles. | H. D. Brown. | " | E. S. Coburn. | H. L. Waldo. |
| 1878. | William Gulick, Watkins | *A. R. Wright. | W. M. L. Fiske. | A. P. Throop. | " | " | " |
| 1879. | Asa S. Couch, Fredonia. | Alfred K. Hills. | E. Hasbrouck. | J. J. Mitchell. | H. L. Waldo. | " | *A. P. Hollett. |
| 1880. | *A. R. Wright, Buffalo. | E. Hasbrouck. | *N. Osborne. | R. A. Adams. | " | " | " |
| 1881. | Selden H. Talcott, Middletown. | J. J. Mitchell. | A. J. Frantz. | *G. W. Peer. | *A. P. Hollett. | " | *C. E. Jones. |
| 1882. | J. J. Mitchell, Newburgh. | E. Hasbrouck. | W. B. Kenyon. | W. M. Butler. | " | " | NECROLOGIST |
| 1883. | Everitt Hasbrouck, Brooklyn. | W. B. Kenyon. | A. P. Williamson. | L. A. Clark. | " | " | *A. W. Holden. |
| 1884. | Edward S. Coburn, Troy. | Henry C. Houghton. | *H. M. Dayfoot. | *A. P. Hollett. | John L. Moffat. | H. L. Waldo | " |
| 1885. | Marshall O. Terry, Utica. | *A. P. Hollett. | N. B. Covert. | George M. Dillow. | " | E. S. Coburn. | " |
| 1886. | Henry C. Houghton, New York. | F. Park Lewis. | *T. L. Brown. | E. W. Bryan. | *H. M. Dayfoot. | " | " |
| 1887. | Horace M. Paine, Albany. | Wm. Tod Helmuth. | J. M. Lee. | Geo. E. Gorham. | " | " | " |
| 1888. | Wm. Tod Helmuth, New York. | Thos. D. Spencer. | *L. A. Bull. | John L. Moffat. | " | Arthur B. Norton. | " |
| 1889. | *Herbert M. Dayfoot, Rochester. | F. F. Laird. | J. T. Greenleaf. | Sidney F. Wilcox. | John L. Moffat. | " | H. L. Waldo. |
| 1890 | George M. Dillow, New York. | N. B. Covert. | J. M. Lee. | W. B. Gifford. | " | " | " |
| 1891. | F. Park Lewis, Buffalo. | A. B. Norton. | L. L. Brainard. | J. W. Sheldon. | " | Charles Deady. | H. D. Schenck. |
| 1892. | Wm. M. L. Fiske, Brooklyn. | *L. A. Bull. | E. J. Bissell. | J. W. Candee. | " | " | " |
| 1893. | J. M. Lee, Rochester. | J. W. Candee. | W. J. Garnsey. | Mary A. Brinkman. | " | " | E. Hasbrouck. |
| 1894. | Jas. Montfort Schley, New York. | E. J. Bissell. | W. B. Gifford. | W. B. Winchell. | " | " | " |
| 1895. | *Charles E. Jones, Albany. | W. B. Gifford. | D. J. Roberts. | W. L. Hartman. | " | " | " |
| 1896. | Edwin H. Wolcott, Rochester. | G. G. Shelton. | I. Townsend. | *A. R. Wright. | " | " | W. S. Garnsey. |
| 1897. | Eugene H. Porter, New York. | John W. Le Seur. | J. W. Dowling. | E. G. Cox. | " | " | " |
| 1898. | A. B. Norton, New York. | D. G. Wilcox. | F. W. Adriance. | H. D. Schenck. | " | " | " |
| 1899. | J. W. Sheldon, Syracuse. | F. W. Adriance. | G. E. Gorham. | N. M. Collins. | " | " | " |
| 1900. | William Morris Butler, Brooklyn. | E. W. Bryan. | L. A. Martin. | Emily F. Swett. | DeWitt G. Wilcox. | Charles Deady. | " |
| 1901. | Jno. T. Greenleaf, Owego. | C. T. Haines. | E. G. Cox. | W. H. Bishop. | " | W. B. Gifford. | " |

**MEMBERS DROPPED FOR NON-PAYMENT OF DUES.**

(*By-Law III, §3, ¶2.*)

Anderson, H. A.....1898
Bachman, Geo. A.....1901
Banker, P. A.....1898
Bass, E. C.....1884
Beach, G. H.....1884
Birdsall, W. G.....1901
Bigelow, J. G.....1884
Bleecker, W. H.....1901
Blighton, W. V-R.....1898
Blodgett, T. L.....1884
Bloss, R. D.....1884
Bolan, L. W.....1901
Boocock, Robert.....1900
Boyce, C. W.....1885
Bradner, Ira S.....1889
Brown, H. D.....1884
Bull, A. T.....1884
Burdick, A. H.....1900
Campbell, C. E.....1891
Campbell, M. W.....1884
Carpenter, L. W.....1898
Carr, A. B.....1892
Chamberlain, J. H.....1894
Chase, C. E.....1898
Clark, A. J.....1889
Clark, F. W.....1900
Coffin, W. H.....1888
Cole, D. D.....1900
Cowl, W. Y.....1894
Crandall, E. L.....1900
Curtiss, A. M.....1895
Dake, Addie B.....1894
Dewey, W. A.....1898
Diehl, W.....1898
Dods, A. Wilson.....1888
Doolittle, J. F.....1889
Finch, Joseph.....1887
Fisher, E. A.....1895
Fiske, Katrina C.....1898
Flint, E. H.....1895
Fulford, G. H.....1888
Fuller, H. E.....1890
Gallup, M. W.....1889
Gamman, A. M.....1893
Gifford, B. R.....1890
Gifford, G. A.....1884
Goodrich, S. W.....1900
Grant, B. F.....1888
Greeley, G. H.....1884
Groves, C. A.....1893
Gwynn, W. M.....1884
Hadley, W. A. M.....1898
Hadley, C. H.....1900
Halbert, John S.....1896
Hale, C. D.....1888
Hand, George F.....1895
Hanford, Harold W.....1896
Hanford, S. C.....1884
Hanford, W. H.....1884
Hanor, Azro Chase.....1896
Hathaway, W. E.....1893
Hawley, W. A.....1884
Hibbard, G. C.....1884
Houghton, B. L.....1893
King, G. H.....1888
Linendall, R. A.....1889
Lindsey, J. S.....1887
Long, William E.....1892
Loomis, E.....1883
Lowery, C.....1884
McCrea, P. A.....1900
MacIvor, Abbie H.....1898
Marsh, James M.....1896
McKenzie, J. E.....1898
McKinney, Susan S.....1898
McMasters, Mrs. M.....1900
McPherson, J. C.....1892
Miller, Isaac.....1886
Millspaugh, C. F.....1890
Moore, J. de V.....1892
Morgan, E. J., Jr.....1887
Mosher, Charles M.....1892
Nash, E. B.....1890
Otis, Clark.....1892
Palmer, G. B.....1890
Pearsall, S. J.....1898
Peckham, J. J.....1888
Peterson, O. W.....1889
Pritchard, G. C.....1898
Proctor, J. C.....1893
Rabe, F. E.....1901
Radway, C. W.....1900
Raymond, J. C.....1883
Reynolds, P. L. F.....1884

Rice, A. B.....1886
Robinson, E. H.....1898
Robinson, R. W.....1895
Rodenberger, E. M.....1898
Seegar, F.....1893
Seeley, W. W.....1893
Smith, Sidney E.....1898
Stebbins, J. H.....1893
Stobbs, A. V.....1888
Sweeting, M. F.....1884
Sweeting, S. C.....1898
Swift, Charles L.....1884
Thorn, Sarah E.....1892
Tracy, G. A.....1888
True, R. S.....1892
Truman, I. P.....1889
Voak, J. B.....1891
Walker, C. E.....1900
Wallace, A. E.....1884
Walters, C. A.....1898
Ward, H. J.....1884
Warren, S. C.....1884
Weed, Robert M.....1891
Welch, C. D.....1891
Wellman, W. I.....1888
West, James A.....1892
White, J. N.....1884
White, W. Hanford.....1888
Whiton, Alpha M.....1895
Winterburn, G. W.....1898
Woodbury, W. L.....1886
Wright, F. M.....1890
Young, C. H.....1898
Zoller, W.....1888

## MEMBERS-ELECT WHO FAILED TO QUALIFY.

Archer, D. E.....1894
Ayres, E. F. M.....1899
Barnum, F. L.....1894
Bennett, D. G.....1894
Campbell, E. E.....1893
Chaplain, F. T.....1881
Conklin, Fannie Donovan..1899
Dyer, Charles L.....1895
Evans, C. V. S.....1894
Fairbank, Stuart J.....1899
Gayde, E. Appleton.....1900
Gifford, Alden.....1892
Hodge, John W.....1899
Kaiser, R. C.....1894
Knight, S. H.....1893
McKenzie, J. A.....1895
Read, J. S.....1891
Reed, J. A.....1894
Wilcox, F. P.....1893
Zimmermann, Charles.....1892

## PERMANENT MEMBERS.

(*Senior Members in Small Capitals.*)

Adams, George F.....Collins State Hospital, Gowanda, 1898
Adams, Myron H.....821 Granite Building, Rochester, 1892
Adams, R. A.....46 N. Fitzhugh, Rochester, 1899
Adriance, F. W.....306 Lake, Elmira, 1883
Albertson, C. S.....9 W. Bridge, Oswego, 1900
Allan, Arthur G.....14 W. 32d, New York, Mhn., 1895
Allen, Emma T. P.....310 Clermont Ave., New York, Bkn., 1899
Allen, Herbert C.....310 Clermont Ave., New York, Bkn., 1899
Allen, Paul.....3 E. 48th, New York, Mhn., 1892
Allen, T. F.....3 E. 48th, New York, Mhn., 1879
Ambler, J. Edgar.....134 East 19th St., New York, Mhn., 1893
Andrews, B. P.....103 Main, Dansville, 1893
Arthur, Daniel H.....Collins State Hospital, Gowanda, 1891
Ashley, M. C.....Middletown, 1894
Austin, Edson C.....Elkhorn, Wis., 1896

| | | |
|---|---|---|
| Avery, E. W. | 16 Hancock, New York, Bkn., | 1889 |
| Babbitt, Otis H. | 178 Genesee, Auburn, | 1892 |
| Baker, Jennie v. H. | 512 Bedford Ave., New York, Bkn., | 1889 |
| Baldwin, G. E. | 500 University Ave., Syracuse, | 1898 |
| Baldwin, Jared G. | 8 E. 41st, New York, Mhn., | 1894 |
| Ball, Halsey J. | Scott, | 1891 |
| Barnard, J. S. | 2112 N. Charles St., Baltimore, Md., | 1886 |
| Barnes, Charles F. | Weedsport, | 1893 |
| Barnes, Frank H. | Stamford, Ct., | 1896 |
| Barrus, Clara | Middletown, | 1894 |
| Baylies, B. L'B. | 418 Putnam Ave., New York, Bkn., | 1883 |
| Beals, Herbert | 176 Franklin, Buffalo, | 1899 |
| Bell, Willard N. | 6 Greene, Ogdensburgh, | 1890 |
| Bennet, G. H. R. | 21 S. Portland Ave., New York, Bkn., | 1889 |
| Benson, R. F., Jr. | 2 St. Paul Pl., Troy, | 1886 |
| Berghaus, Alex. | 138 E. 65th, New York, Mhn., | 1888 |
| Besemer, Martin | 40 S. Albany, Ithaca, | 1897 |
| Best, F. W. | 66 Ball, Port Jervis, | 1893 |
| Beyea, J. L. | 217 Second Ave., New York, Mhn., | 1894 |
| Bierbauer, Bruno W. | 85 Pierrepont, New York, Bkn., | 1898 |
| Birch, Chas. E. | White Plains, | 1894 |
| Birdsall, S. T. | 80 Ridge, Glens Falls, | 1883 |
| Birdsall, T. P. | Patterson, | 1892 |
| Bishop, F. M. | Newark Valley, | 1891 |
| Bishop, W. H. | 46 W. 48th, New York, Mhn., | 1893 |
| Bissell, E. J. | 75 S. Fitzhugh, Rochester, | 1889 |
| Blackley, C. A. | 247 Washburn St., Lockport, | 1901 |
| Blackman, W. W. | 519 Clinton Ave., New York, Bkn., | 1890 |
| Bond, Mary E. | 122 Lexington, New York, Mhn., | 1892 |
| Bonnell, Chas. L. | 3 Hanson Pl., New York, Bkn., | 1879 |
| Borden, G. T. | Caledonia, | 1887 |
| Boyle, Chas. C. | 49 W. 37th, New York, Mhn., | 1888 |
| Boynton, F. H. | 36 W. 50th, New York, Mhn., | 1888 |
| Brainard, L. L. | 2 Cronkhite Block, Little Falls, | 1883 |
| Brinkman, Mary A. | Brewster, | 1891 |
| Brown, E. V. | N. Tarrytown, | 1886 |
| Brown, M. Belle | 135 W. 34th, New York, Mhn., | 1892 |
| BRYAN, E. W. (1900) | Corning, | 1880 |
| Bryant, Wm. C. | 64 Greene Ave., New York, Bkn., | 1899 |
| Buchholz, Louise Z. | 73 E. 8th, New York, Mhn., | 1892 |
| Buell, E. S. (Lic.) | South Greece, | 1893 |
| Buell, Jesse W. | 61 Clinton Ave., S., Rochester, | 1889 |
| BULLARD, D. H. (1887) | Glens Falls, | 1864 |
| Bulmer, Geo. W. | 1210 Bushwick Ave., New York, Bkn., | 1891 |
| Burnham, Clark | 182 Clinton, New York, Bkn., | 1889 |
| Butler, Wm. M. | 507 Clinton Ave., New York, Bkn., | 1881 |
| Caldwell, Frank E. | 151 Henry, New York, Bkn., | 1889 |
| Calisch, Alex. C. | 55 W. Bridge, Oswego, | 1896 |
| Candee, J. W. | 501 Fayette Park, Syracuse, | 1885 |
| Capron, C. G. | Utica, | 1900 |

| | | |
|---|---|---|
| Carleton, Bukk G..... | 75 W. 50th, New York, Mhn., | 1892 |
| CARROLL, S. H. (1900).. | 234 State, Albany, | 1874 |
| Case, Walter R..... | 239 Mill, Poughkeepsie, | 1886 |
| Cassidy, Georgia A..... | 703 Nostrand Ave., New York, Bkn., | 1891 |
| Chadwick, John G..... | 382 Franklin St., Buffalo, | 1899 |
| Chamberlin, W. T..... | 127 Seventh Ave., New York, Bkn., | 1899 |
| Chandler, D. Henry.... | Cornwall-on-Hudson, | 1894 |
| Chapin, Edward..... | 21 Schermerhorn, New York, Bkn., | 1883 |
| Charles, Emily C..... | 51 W. 127th, New York, Mhn., | 1898 |
| Chase, J. Oscoe..... | 214 E. 53d, New York, Mhn., | 1888 |
| Church, Geo. H. (Lic.).. | Oaks Corners, | 1891 |
| Church, H. A..... | 601 Warren, Syracuse, | 1898 |
| Clark, Byron G..... | 162 W. 122d, New York, Mhn., | 1891 |
| Clark, L. A..... | Cambridge, | 1879 |
| Clapp, Charles R..... | 427 Hayward Ave., Rochester, | 1901 |
| Coburn, Edward S..... | 94 Fourth, Troy, | 1874 |
| Cochrane, H. D..... | 175 Hamilton, Albany, | 1900 |
| Collins, N. M..... | 43 East Ave., Rochester, | 1886 |
| Cook, C. P..... | Hudson, | 1872 |
| Cook, J. T..... | 636 Delaware Ave., Buffalo, | 1883 |
| Cooper, C. S..... | Skaneateles, | 1896 |
| Cornell, C. W..... | W. 72d & Boulevard, New York,Mhn., | 1884 |
| Corwin, Elizabeth..... | 104 Main, Binghamton, | 1892 |
| COUCH, ASA S. (1894)... | Fredonia, | 1864 |
| Covert, N. B..... | Geneva, | 1878 |
| Covert, Rynear B..... | Seneca Falls, | 1892 |
| Cox, Edward G..... | 261 State, Albany, | 1894 |
| Cox, F. J..... | 109 State, Albany, | 1894 |
| Cox, G. A..... | 80 S. Swan, Albany, | 1878 |
| Critchlow, Geo. Reed... | 505 Norwood, Buffalo, | 1901 |
| Crum, Harry Herbert... | 212 Hazen St., Ithaca, | 1901 |
| Danforth, L. L..... | 59 W. 52d, New York, Mhn., | 1888 |
| Davies, Thomas F..... | 359 W. 116th St., New York, Mhn., | 1901 |
| Davis, J. E. L..... | 743 Madison Ave., New York, Mhn., | 1891 |
| Deady, Charles..... | 110 W. 48th, New York, Mhn., | 1888 |
| Deady, H. P..... | Liberty, | 1899 |
| Dean, L. W..... | Waterville, | 1899 |
| Dearborn, H. M..... | 146 W. 57th, New York, Mhn., | 1888 |
| De Camp, Frank H..... | Horseheads, | 1901 |
| Decker, W. M..... | 242 Ashland, Buffalo, | 1883 |
| De La Barre, W. C..... | 224 W. 59th, New York, Mhn., | 1894 |
| Demarest, J. H..... | 1969 Madison Ave., New York, Mhn., | 1892 |
| Denison, R. N..... | 55 Eighth Ave., New York, Bkn., | 1899 |
| Denslow, M. H..... | Marbledale, Conn., | 1894 |
| Deschere, Martin..... | 334 W. 58th, New York, Mhn., | 1889 |
| Deuel, W. Estus..... | Chittenango, | 1891 |
| Dillingham, T. M..... | 8 W. 49th. New York, Mhn., | 1891 |
| Dillow, George M..... | 57th and Broadway, New York, Mhn., | 1889 |
| Doane, W. H..... | Pittsford, | 1893 |
| Doty, G. H... ..... | 245½ Cumberland, New York, Bkn., | 1892 |

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| Doughty, Francis E.... | 512 Madison Ave., New York, Mhn., | 1877 |
| Dowling, J. Ivimey..... | 214 State, Albany, | 1900 |
| Dowe, F. LeC..... | 332 Alexander Ave., New York, Mhn., | 1892 |
| Dowling, J. W..... | 8 W. 45th, New York, Mhn., | 1889 |
| Drury, Alfred..... | 457 W. 147th St., New York, Mhn., | 1901 |
| DuBois, W. C..... | 519 S. Salina, Syracuse, | 1893 |
| Dutcher, M. T..... | Owego, | 1884 |
| Eddy, Ermina C..... | 500 William, Elmira, | 1883 |
| Eife, A. F..... | 175 W. 10th, New York, Mhn., | 1888 |
| Eisenbrey, E. H..... | Gloversville, | 1897 |
| Elliott, Amos H..... | 480 Monroe, New York, Bkn., | 1890 |
| Erb, Peter..... | 32 Palace Arcade, Buffalo, | 1891 |
| Fancher, E..... | 16 Orchard, Middletown, | 1885 |
| Faust, Louis..... | 19 Jay, Schnectady, | 1885 |
| Faust, Wm. P..... | 29 Jay, Schnectady, | 1898 |
| Fay, R. P..... | 165 Warburton Ave., Yonkers, | 1892 |
| Ferrier, James..... | 166 E. 111th, New York, Mhn., | 1896 |
| FISKE, WM. M. L. (1900). | 484 Bedford Ave., New York, Bkn., | 1875 |
| Fiske, E. Rodney..... | 488 Nostrand Ave., New York, Bkn., | 1896 |
| Follet, W. M..... | Seneca Falls, | 1891 |
| Foster, E. Agate..... | Patchogue, | 1891 |
| Foster, Henry..... | Clifton Springs, | 1891 |
| Foster, H. A..... | 3 St. John's Pl., Buffalo, | 1891 |
| Foster, W. E..... | Glen Cove, | 1892 |
| Fowler, W. P..... | 63 Clinton Ave., S., Rochester, | 1876 |
| Fralick, W. G..... | 778 Madison Ave., New York, Mhn., | 1892 |
| Francisco, D. E..... | Middletown, | 1897 |
| Franklin, E. D..... | 325 W. 14th, New York, Mhn., | 1888 |
| Frazer, F. M..... | 41 W. 45th, New York, Mhn., | 1894 |
| Frazier, L. A..... | 124 Division, Amsterdam, | 1892 |
| Frye, M. M..... | 167 Genesee, Auburn, | 1884 |
| Garnsey, W. S..... | 93 N. Main, Gloversville, | 1888 |
| Garrison, J. B..... | 111 E. 70th, New York, Mhn., | 1888 |
| Getman, A. D..... | 17 Ford Ave., Oneonta, | 1893 |
| Gifford, G. L..... | Hamilton, | 1868 |
| Gifford, W. B..... | Attica. | 1886 |
| Gillespie, Lizzie S..... | 266 Monroe St., New York, Mhn., | 1889 |
| Gillette, Myra A..... | Medina, | 1891 |
| Given, J. B..... | 463 Ninth St., Brooklyn, | 1900 |
| Givens, A. J..... | Stamford, Conn., | 1891 |
| Gore, Jennie E..... | 1145 Park Ave., New York, Mhn., | 1892 |
| Gorham, G. E..... | 214 State St., Albany, | 1900 |
| Gorton, D. A..... | 174 Clinton, New York, Bkn., | 1890 |
| Graham, M. E..... | 10 Jones Ave., Rochester, | 1893 |
| Grant, A. R..... | 366 Genesee St., Utica, | 1901 |
| Greene, C. R. F..... | Peekskill, | 1894 |
| Greenleaf, J. T..... | Owego, | 1884 |
| Gregory, G. W..... | 370 W. Church, Elmira, | 1895 |
| Gridley, G. L..... | 605 Warren, Syracuse, | 1895 |
| GUERNSEY, EGBERT (1899) | 180 W. 59th, New York, Mhn., | 1865 |

GULICK, WILLIAM (1885). Watkins, 1865
Guy, Clement N..... Greene, 1901
Gwynn, Charles A.....13 Grover, Auburn, 1899
Gwynn, William M.....14 Grover St., Auburn, 1901
Haines, C. T.....68 South St., Utica, 1891
Hall, M. J..... Mamaroneck, 1893
Hallock, J. H.....Saranac Lake, 1880
Hamlin, F. W.....130 W. 48th, New York, Mhn., 1892
Hardy, W. J..... Belmont, 1901
Hartley, W. G..... 345 W. 34th, New York, Mhn., 1891
Hartman, W. L.....601 Warren, Syracuse, 1893
HASBROUCK, E. (1901).. 369 Ninth, New York, Bkn., 1873
Hasbrouck, Joseph..... Dobb's Ferry, 1899
Hasbrouck, Sayer..... 117 Broad, Providence, R. I., 1883
Hathaway, H. S.....146 W. 92d, New York, Mhn., 1892
HAVILAND, N. H. (1901). Fulton, 1880
Hawley, H. Reed.....Staatsburgh, 1897
Hawley, L. B.....Clyde, 1893
Haywood, Chas. W.....Stamford, Conn., 1898
Haywood, George M... 48 Clinton Ave., S., Rochester, 1890
Haywood, Mrs. Julia F..612 West Ave., Rochester, 1890
Helfrich, C. H.....542 Fifth Ave., New York, Mhn., 1888
Helmuth, William Tod..504 Fifth Ave., New York, Mhn., 1873
Helmuth, W. T., Jr.....465 Lexington Ave., New York, Mhn., 1888
Hibbard, D. M.....112 Berry, Olean, 1893
Hill, Emily L.....Gloversville, 1899
Hinman, E. L.....84 W. Oneida, Oswego. 1898
Hodge, W. H.....8 Gluck Block, Niagara Falls, 1895
Honan, W. F.....W. 71st & Gr'd Boulev'd, N. Y., Mhn., 1894
Hopkins, W. W.....Geneva, 1894
Horton, E. T.....Whitehall, 1897
Hough, W. D.....Niagara Falls, 1891
Howe, J. M.....58 W. 47th, New York, Mhn., 1894
Howland, R. B.....306 Lake, Elmira, 1897
Hoyt, E. F..... 39 W. 58th, New York, Mhn., 1894
Hoyt, Gordon W.....808 Madison, Syracuse, 1898
Hoyt, H. W.....75 S. Fitzhugh, Rochester, 1893
Hunt, Dwight B.....159 Madison Ave., New York, Mhn., 1887
HUNTING, NELSON (1897) 155 Hamilton, Albany, 1872
Hurd, S. Wright.....78 Main, Lockport, 1891
Hutchins, H. S..... Batavia, 1870
Hyde, L. D..... Montclair, N. J., 1894
Jacobson, Frank A..... 269 Grand, Newburgh, 1891
Jeffery, George C.....343 Jefferson Ave., New York, Bkn., 1887
Jenkins, George H.....Binghamton, 1897
Johnston, C. L..... 467 Vanderbilt Ave., New York, Bkn., 1890
Kastendieck, J. T. W... 149 Keap, New York, Bkn., 1890
Keator, Bruce S.....Asbury Park, N. J., 1894
Keegan, Wm. A.....44 Clinton Ave., S., Rochester, 1890

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| Keese, J. Mumford..... | 211 Schonnard, Syracuse, | 1899 |
| Keith, Horace G..... | 107 S. Broadway, Yonkers, | 1895 |
| Kellogg, Chas. M..... | 38 Clinton Ave., N., Rochester, | 1889 |
| KELLOGG, E. M. (1894).. | 115 E. 37th, New York, Mhn., | 1866 |
| Kenyon, W. B..... | 13 E. Swan, Buffalo, | 1883 |
| King, Wm. Harvey..... | 64 W. 51st, New York, Mhn., | 1886 |
| Kingsley, O. D..... | White Plains, | 1897 |
| Kinne, A. B..... | Fayette Park, Syracuse, | 1882 |
| Kinne, E. O..... | 516 Warren, Syracuse, | 1899 |
| Klots, E. D..... | 156 W. 48th, New York, Mhn., | 1899 |
| Knapp, James C..... | Geneva, | 1892 |
| Laidlaw, Alexander H.. | 137 W. 41st, New York, Mhn., | 1897 |
| Laidlaw, Geo. F..... | 57 W. 53rd, New York, Mhn., | 1894 |
| Laird, F. F..... | 236 Genesee, Utica, | 1883 |
| Land, Joseph F..... | 130 W. 126th, New York, Mhn., | 1888 |
| Lane, Charles E..... | 289 Mill, Poughkeepsie, | 1893 |
| Lane, Irwin J..... | 2 Church, Sing Sing, | 1892 |
| Langworthy, Annie L... | 1381 Boston Ave., New York, | 1900 |
| Lannin, Louise..... | 148 W. 85th, New York, Mhn., | 1895 |
| Latimer, W. C..... | 351a Clinton, New York, Bkn., | 1884 |
| Lauer, C. F..... | 248 Emerson Pl., New York, Bkn., | 1891 |
| Lawrence, J. B..... | 289 Ninth, New York, Bkn., | 1894 |
| Lazarus, Geo. F..... | 6 Caton Ave., New York, Bkn., | 1900 |
| Leal, Malcolm..... | 107 W. 48th, New York, Mhn., | 1888 |
| Lee, J. M..... | 121 Lake Ave., Rochester, | 1884 |
| Leonard, Wm. H..... | Tully, | 1899 |
| LeSeur, John W..... | 207 E. Main, Batavia, | 1890 |
| Lewis, Fred D..... | 188 Franklin, Buffalo, | 1893 |
| Lewis, F. Edward..... | Cambridge, | 1891 |
| Lewis, F. Park..... | 454 Franklin, Buffalo, | 1881 |
| Livezey, F. B..... | 2807 N. Broad, Philadelphia, Pa., | 1898 |
| Lloyd, R. I..... | 296—47th St., New York, Bkn., | 1900 |
| Lount, Robert..... | 79 Fulton, Hempstead, | 1893 |
| Low, E. C..... | Plattsburgh, | 1878 |
| MacCallum, John H.... | 404 Monroe Ave., Rochester, | 1890 |
| Macfarland, R. L..... | 53 Clinton Ave., New York, Jamaica, | 1898 |
| Macy, C. S..... | 117 W. 12th, New York, Mhn., | 1895 |
| Madden, J. D..... | Sing Sing, | 1892 |
| Maeder, John G..... | 304 E. 120th, New York, | 1900 |
| Martin, L. A..... | 74 Exchange, Binghamton, | 1892 |
| Martin, T. J..... | 279 North, Buffalo, | 1891 |
| Maycock, B. J..... | 33 Allen, Buffalo, | 1893 |
| McDonald, W. O..... | 117 W. 44th, New York, Mhn., | 1894 |
| McDowell, Chas..... | 110 W. 12th, New York, Mhn., | 1888 |
| McDowell, Geo. W..... | 136 W. 130th, New York, Mhn., | 1892 |
| McGeoch, R. L..... | Goshen, | 1901 |
| McGraw, D. H..... | 96 Court, Binghamton, | 1899 |
| McKown, W. J..... | 335 Hamilton, Albany, | 1895 |
| McMichael, A. R..... | 969 Madison Ave., New York, Mhn., | 1891 |
| Mills, Walter Sands..... | 154 West 119th, New York, | 1900 |

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|---|---|---|
| McMichael, D. A. | 67 W. 96th, New York, Mhn., | 1892 |
| McPherson, P. J. | Millport, | 1899 |
| Merriam, H. E. | Owego, | 1894 |
| Meyer, O. N. | 171 E. 78th, New York, Mhn., | 1896 |
| Milbank, W. E. | 111 State, Albany, | 1879 |
| Miller, C. J. | Mount Kisco, | 1894 |
| Miller, John | 48 St. John's Pl., Buffalo, | 1891 |
| MILLER, R. E. (1898) | Oxford, | 1871 |
| Minton, H. B. | 165 Joralemon, New York, Bkn., | 1888 |
| Mitchell, J. J. | 242 Montgomery, Newburg, | 1880 |
| Moffat, John L. | 1136 Dean St., New York, Bkn., | 1883 |
| Montanye, W. De la | Rondout, Kingston, | 1891 |
| Moseley, G. T. | 202 Delaware Ave., Buffalo, | 1891 |
| Mossman, N. A. | 28 E. 47th, New York, Mhn., | 1892 |
| Mott, O. H. (Lic.) | Fort Ann, | 1897 |
| Muncie, E. H. | 119 Macon, New York, Bkn., | 1890 |
| Muncie, Libbie H. | 119 Macon, New York, Bkn., | 1896 |
| Musits, H. von | 47 E. 83d, New York, Mhn., | 1892 |
| Nead, W. M. | 210 State, Albany, | 1891 |
| Neefus, P. Wyckoff | 124 East Ave., Rochester, | 1896 |
| Neilson, H. S. | 46 W. 48th, New York, Mhn., | 1896 |
| Newman, Louis G. | Brewster, | 1901 |
| Nickelson, W. H. | Adams, | 1889 |
| Noble, E. H. | 410 E. Church, Elmira, | 1894 |
| Norton, A. B. | 16 W. 45th, New York, Mhn., | 1886 |
| Nott, F. J. | 29 E. 55th, New York, Mhn., | 1891 |
| Nottage, Rachel R. | 669 Macon, New York, Bkn., | 1900 |
| O'Connor, J. T. | 29 W. 45th, New York, Mhn., | 1889 |
| Ogden, E. G. | 10 E. 32d, New York, Mhn., | 1894 |
| Ogden, G. S. | 24 Kenilworth Pl., New York, Bkn., | 1898 |
| Ostrander, P. M. | Nunda, | 1894 |
| Ostrom, H. I. | 42 W. 48th, New York, Mhn., | 1886 |
| Otis, C. F. | Honeoye Falls, | 1890 |
| Otis, J. C. | Poughkeepsie, | 1883 |
| Page, Roy A. | Geneseo, | 1895 |
| Paige, H. W. | 256 W. 57th, New York, Mhn., | 1892 |
| PAINE, H. M. (1891) | 67 N. Forsyth, Atlanta, Ga., | 1850 |
| Palmer, A. Worrall | 210 W. 57th, New York, Mhn., | 1899 |
| Parsons, Thomas | 33 Clinton Ave., S., Rochester, | 1896 |
| Partridge, B. S. | East Bloomfield, | 1889 |
| Pearsall, J. A. | Saratoga Springs, | 1882 |
| Pearsall, W. S. | 128 W. 78th, New York, Mhn., | 1896 |
| Pease, C. G. | 101 W. 72d, New York, Mhn., | 1891 |
| Pettet, Isabella M. | 308 E. 15th, New York, Mhn., | 1897 |
| Pettit, A. R. | Patchogue, | 1891 |
| Phillips, R. Oliver | Yonkers, | 1891 |
| Phillips, R. E. | 21 Park Ave., Rochester, | 1898 |
| Pierce, Willard Ide | 64 W. 126th, New York, Mhn., | 1890 |
| Pierron, H. J. | 438 Greene Ave., New York, Bkn., | 1890 |
| Pierson, W. H. | 101 McDonough, New York, Bkn., | 1891 |

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| Porter, E. H. | 181 W. 73d, New York, Mhn., | 1888 |
| Potter, Clarence A. | Gowanda State Hom. Hospital, | 1899 |
| Powelson, A. P. | Middletown, | 1897 |
| PRATT, L. M. (1886) | Homer, | 1864 |
| Preston, H. G. | 54 Greene Ave., New York, Bkn., | 1875 |
| Proctor, W. H. | 25 Main, Binghamton, | 1884 |
| Purdy, M. S. | Corning, | 1887 |
| Queen, L. A. | 261 W. 72d, New York, Mhn., | 1891 |
| Rambo, W. S. | 41 Sophia, Rochester, | 1893 |
| Reynolds, W. U. | 320 Manhattan Ave., New York, Mhn., | 1888 |
| Richardson, A. J. | 39 E. 83d, New York, Mhn., | 1891 |
| Richardson, G. W. | 138 E. 79th, New York, Mhn., | 1891 |
| Ricker, Mrs. M. S. | 58 Lorimer, Rochester, | 1890 |
| Rieger, Joseph | 404 Central Ave., Dunkirk, | 1899 |
| Rink, Walter S. | 295 Halsey, Brooklyn, | 1900 |
| Ritch, A. M. | 711 Putnam Ave., New York, Bkn., | 1891 |
| Ritch, Orando S. | 337a Macon, New York, Bkn., | 1889 |
| Ritchie, F. G. | 131 W. 47th, New York, Mhn., | 1894 |
| Roberts, D. J. | New Rochelle, New York, | 1889 |
| Roberts, G. W. | 170 Central Park, New York, Mhn., | 1891 |
| Robinson, N. | 89 Halsey, New York, Bkn., | 1890 |
| Rockefeller, H. O. | 152 Jerome. New York, Bkn., | 1892 |
| Rodgers, Albert H. | Corning, | 1898 |
| Roe, J. F. | 25 Main, Binghamton, | 1897 |
| Rounds, W. E. | 154 W. 47th, New York, Mhn., | 1889 |
| Rowley, C. A. | Victor, | 1890 |
| Royal, T. C. | Ballston Spa, | 1888 |
| Rudderow, E. D. | 233 W. 83d, New York, Mhn., | 1896 |
| Russell, H. Everett | 30 E. 74th, New York, Mhn., | 1892 |
| Russell, J. E. | 1036 Bedford Ave., New York, Bkn., | 1889 |
| Sanders, L. J. | 421 Monroe Ave., Rochester, | 1897 |
| Santway, F. L. | Theresa, | 1896 |
| Schall, J. Hubley | 141 St. Mark's Ave., New York, Bkn., | 1901 |
| Schenck, H. D. | 241 McDonough, New York, Bkn., | 1887 |
| Schley, J. M. | 32 W. 49th, New York, Mhn., | 1889 |
| Schumann, C. | Delhi, | 1892 |
| Scott, W. H. | 104 W. 44th, New York, Mhn., | 1888 |
| Scudder, N. C. | 506 N. James, Rome, | 1898 |
| SEARLE, W. S. (1894) | 62 Clark, New York, Bkn., | 1865 |
| Seitz, F. B. | 33 N. Pearl, Buffalo, | 1897 |
| Severance, B. W. | Gouverneur, | 1897 |
| Seward, F. W. | Goshen, | 1891 |
| Seward, F. W., Jr. | Goshen, | 1901 |
| Seymour, G. W. | Westfield, | 1883 |
| Shattuck, J. W. M. | Westport, | 1897 |
| Shaw, J. C. | Hoosick Falls, | 1885 |
| Sheldon, Jay W. | 501 Fayette Park, Syracuse, | 1885 |
| Shelton, G. G. | 521 Madison Ave., New York, Mhn., | 1886 |
| Shepard, G. A. | Broadway and 52d, New York, Mhn., | 1892 |
| Sherman, I. P. | 114 W. 44th, New York, Mhn., | 1894 |

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| Sherwood, Bradford Wyckoff, | 1117 S. Salina St., Syracuse, | 1901 |
| Simmons, D. | 1188 Dean, New York, Bkn., | 1884 |
| Simmons, R. S. | 129 E. 59th, New York, Mhn., | 1891 |
| Simmons, Silas S. | Susquehanna, Penn., | 1885 |
| Simonson, J. T. | 46 W. 85th, New York, Mhn., | 1901 |
| Simpson, E. D. | 320 W. 115th, New York, Mhn., | 1899 |
| Skinner, S. W. | Le Roy, | 1887 |
| Slaught, J. E. | Warsaw, | 1883 |
| Smith, F. R. | 400 Main E., Rochester, | 1893 |
| SMITH, HENRY M. (1895). | 288 St. Nicholas Av., New York, Mhn., | 1866 |
| Smith, O. W. | Union Springs, | 1884 |
| Smith, St. Clair | 25 W. 50th, New York, Mhn., | 1891 |
| SMITH, T. F. (1894) | 264 Lenox Ave., New York, Mhn., | 1871 |
| Snow, S. R. | 267 Alexander Ave., Rochester, | 1893 |
| Snyder, E. E. | 27 Main, Binghamton, | 1883 |
| SOUTHWICK, A. B. (1898). | Rome, | 1871 |
| SOUTHWICK, D. E. (1900). | Ogdensburgh, | 1867 |
| Spencer, T. D. | 24 Union, S., Rochester, | 1884 |
| Spire, C. E. | Clyde, | 1898 |
| Spoor, D. E. | N. Granville, | 1883 |
| Stanton, L. M. | 132 W. 58th, New York, Mhn., | 1895 |
| Stearns, G. R. | 201 Linwood Ave., Buffalo, | 1893 |
| Stevens, D. D. | 49—83rd, New York, Mhn., | 1894 |
| Stewart, J. A. | 1030 Bedford Ave., New York, Bkn., | 1892 |
| Stewart, W. A. | Dupont Circle, Washington, D. C., | 1895 |
| Stiles, H. R. | F. Humphrey & Son, New York, Mhn., | 1885 |
| Storer, J. H. | 30 Edgecomb Ave., New York, Mhn., | 1892 |
| Street, H. E. | 98 Brooklyn Ave., New York, Bkn., | 1894 |
| Strong, C. H. | 410 Nat. Union Bldg., Toledo, O., | 1892 |
| Stumpf, D. B. | 693 Ellicott, Buffalo, | 1885 |
| Sumner, C. R. | 33 Clinton Ave., S., Rochester, | 1882 |
| Sweeting, W. H. | Savannah, | 1890 |
| Swett, Emily F. | Medina, | 1892 |
| Swift, E. P. | 170 W. 88th, New York, Mhn., | 1888 |
| Sword, G. P. | Huntington, L. I., | 1900 |
| Talcott, Selden H. | Middletown, | 1874 |
| Talmage, S. | 22 Schermerhorn, New York, Bkn., | 1899 |
| Teets, C. E. | 37 W. 39th, New York, Mhn., | 1888 |
| Terry, M. O. | 196 Genesee, Utica, | 1876 |
| Thatcher, E. P. | Main St., Newark, | 1893 |
| Thompson, V. | 56 W. 21st, New York, Mhn., | 1888 |
| Throop, A. P. | Port Gibson, | 1874 |
| Thurber, T. J. | 157 Plymouth Ave., Rochester, | 1889 |
| Townsend, Irving | 67 W. 46th, New York, Mhn., | 1891 |
| Trotter, R. R. | Yonkers, | 1890 |
| Turner, T. S. | 231 Chenango, Binghamton, | 1897 |
| Tuttle, E. G. | 61 W. 51st, New York, Mhn., | 1892 |
| Tytler, G. E. | 113 W. 126th, New York, Mhn., | 1889 |
| Van Buren, B. L. (Lic.). | Lebanon Springs, | 1897 |
| Van Buren, Hattie C. | 163 Halsey, New York, Bkn., | 1895 |

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| Van Denburg, M. W... | Mount Vernon, | 1887 |
| Van den Burg, W. H.... | 32 W. 49th, New York, Mhn., | 1897 |
| Van Derwerker, H. W.. | Sandy Hill, | 1897 |
| Van Loon, A. B..... | 50 Eagle, Albany, | 1894 |
| Van Ostrand, D. G..... | Candor, | 1899 |
| Vehslage, S. H..... | 117 W. 43d, New York, Mhn., | 1891 |
| Vibbard, Arthur A..... | Sloanville, | 1901 |
| Vincent, Stanley..... | 262 Main, Catskill, | 1899 |
| Von der Lühe, A..... | 245 Hooper, New York, Bkn., | 1883 |
| Wait, Phoebe J. B..... | 34th and 9th Ave., New York, Mhn., | 1900 |
| Waldo, H. L..... | 1834 Fifth Ave., Troy, | 1879 |
| Walrad, C. B..... | Johnstown, | 1889 |
| Ward, C. A..... | 33 Court, Binghamton, | 1890 |
| Warner, A. G..... | 19 Schermerhorn, New York, Bkn., | 1888 |
| Warner, F. P..... | Canandaigua, | 1893 |
| WATSON, W. H. (1891).. | 270 Genesee, Utica, | 1869 |
| Wetmore, J. McE..... | 43 W. 54th, New York, Mhn., | 1892 |
| White, A. Lenora..... | 151 W. 46th, New York, Mhn., | 1892 |
| White, J. C..... | Portchester, | 1891 |
| Wiggins, T. C..... | 76 Macon, New York, Bkn., | 1894 |
| Wilcox, DeWitt G..... | 597 Elmwood Ave., Buffalo, | 1887 |
| Wilcox, Sidney F..... | 51 W. 52d, New York, Mhn., | 1891 |
| Williams, F. F..... | 6 Goodrich, Canton, | 1892 |
| Williams, T. C..... | 118 E. 19th, New York, Mhn., | 1892 |
| Williamson, B..... | Friendship, | 1893 |
| Willis, H., Jr..... | 1303 Dean, New York, Bkn., | 1892 |
| Winchell, W. B..... | 137 Berkeley Pl., New York, Bkn., | 1889 |
| Wolcott, E. H..... | 57 Union St., Rochester, | 1886 |
| Woodman, Robert C.... | Middletown, | 1900 |
| Woodruff, A. J..... | Babylon, | 1891 |
| Wright, J. G..... | 363 Eleventh St., New York, Bkn., | 1900 |
| Zwetsch, J. D..... | Gowanda, | 1883 |

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**DELEGATE MEMBERS.**

CLASS C.

*Terms expire with the Annual Meeting in 1902.*

*Kings County,* Brooklyn. 19—Aten, W. H., 83 Greene Ave.
Ayres, Rebecca J., 509 Van Buren.
Bedford, E. R., 153 Tompkins Ave.
Broughton, L. D., Jr., 418 Madison.
Buys, T. L., 1483 Bedford Ave.
Cameron, Elizabeth W. M., 23 Seventh Ave.
Clarke, M. Elizabeth, 8 Lafayette Ave.
Cort, Lottie A., 89 Division Ave.
Devol, E., 114 Milton.
Fawdray, J. W., 242 Clermont Ave.

Iler, G. H., 237 McDonough.
Love, W. L., 1188 Dean.
McLenathan, W. H., 101 Division Ave.
Moon, W. W., 184 Macon.
Palmer, G. Howard, 90 Hancock.
Shrewsbury, W. J., 238 Keap.
Stolz, Rosalie H., 778 Putnam Ave.
Underhill, A. E., 465 Hancock.
Walmsley, R. F., 491 Putnam Ave.

## CLASS D.

*Terms expire with the Annual Meeting in 1903.*

*Albany County,* 4—Spoor, W. D., 168 Lafayette, Schenectady.
Marshall, Dr., Albany.
Towne, F. L., Schenectady.
Gannett, Dr., Albany.
*Chenango County,* 1—Ganow, G. J., Oxford.
*Madison County,* 1—
*Montgomery County,* 1—Knott, Harriet A., Gloversville.
*Onondaga County,* 3—Chaffee, R. W., 1701 Genesee, Syracuse.
Keeler, E. E., 452 Salina, Syracuse.
Lukens, C. M., 117 E. Jefferson, Syracuse.
*Ontario County,* 1—Mitchel, C. T., Canandaigua.
*Mass. Med. Society Delegates,* 2—N. Emmons Paine, W. Newton, Mass.
J. P. Rand, Monson, Mass.

## CLASS A.

*Terms expire with the Annual Meeting in 1904.*

*New York County,* 34—Allen, J. Wilford, 110 West 12th.
Andrew, R. M., 1777 Bathgate Ave.
Arschagouni, John, 733 Lexington Ave.
Bagg, C. S., 67 West 45th.
Bickford, Lydia A., 45 W. 39th.
Blakeman, J. LeRoy, 1977 Seventh Ave.
Bren, M. R., 1949 Seventh Ave.
Brown, Granville C., 56 W. 45th.
Buchanan, T. D., 328 W. 24th.
Crump, W. G., 693 Madison Ave.
Dunlevy, Rita, 328 W. 7th.
Edwards, Mary L., 19 West 46th.
Hallett, G. DeWayne, 132 West 81st.
Hart, A. H., 130 West 44th.
Hutchinson, John, 80 East 55th.
DuJardin, Roland, 129 East 76th.
Jarrett, Elizabeth, 159 West 48th.
Keatinge, Harriette d'E., 141 West 71st.
Miner, F. C., 1150 Forest Ave.

Morganthaler, Sophia, 129 West 64th.
Munson, Edwin S., 16 West 45th.
Nutter, Mary E., 144 Lexington Ave.
O'Brien, Evelina C. D., 226 East 87th.
Palmer, Helen Cooley, 110 West 84th.
Palmer, J. B., 201 East 23rd.
Seward, J. Perry, 200 West 70th.
Sheldon, Floyd P., 223 West 122d.
Sherman, LeRoy B., 355 West 14th.
Stewart, G. T., Metropolitan Hospital.
Townsend, Charles W., 144 West 46th.
Townsend, Katherine G., 354 West 123d.
Whitehorne, F. N., 64 West 126th.
Worrall, M. Ruth, 239 West 44th.
Wright, Amelia, 5 West 82d.

## CLASS B.

*Terms expire with the Annual Meeting in 1905.*

*Broome County*, 1—Bailey, D. P., 41 Court, Binghamton.
*Dutchess County*, 2—Peckham, A. L., Poughkeepsie.
Embley, Thomas W., Fishkill.
*Jefferson County*, 2—
*Monroe County*, 4—Button, L. L., 265 Alexander, Rochester.
Carman, W. B., 23 Upton Park, Rochester,
Whittleton, E. J., Webster.
Winans, W. W., 33 Clinton Ave. S., Rochester.
*Westchester County*, 3—Ives, N. H., Mt. Vernon.
Mason, P. H., Peekskill.
Haight, A. M., Mt. Vernon.

# DIRECTORY

OF THE

# HOMŒOPATHIC PRACTITIONERS

OF THE

# STATE OF NEW YORK.

DECEMBER, 1901.

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* Permanent Member of State Society.
† Delegate Member of State Society.
‡ Member of County Society.

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In accordance with the wishes of the American Institute of Homœopathy notice of good openings for homœopathists are solicited and will be published.

The thanks of the Society are due (and are hereby acknowledged) to those who have afforded aid in the compilation of this Directory.

All who notice errors will confer a favor upon the profession at large by promptly sending corrections and additions to

DE WITT G. WILCOX,
*Secretary.*

597 Elmwood Avenue,
Buffalo, New York.

The directory this year shows 1406 homœopathic doctors in 342 towns of 59 counties, distributed as follows:

| | | | | | |
|---|---|---|---|---|---|
| ‡Albany | 20 | ‡Jefferson | 21 | Richmond | 4 |
| Allegany | 7 | ‡Kings | 218 | Rockland | 3 |
| ‡Broome | 25 | Lewis | 2 | St. Lawrence | 16 |
| Cattaraugus | 10 | Livingston | 12 | Saratoga | 12 |
| Cayuga | 18 | ‡Madison | 11 | Schenectady | 7 |
| Chautauqua | 18 | ‡Monroe | 83 | Schuyler | 4 |
| Chemung | 15 | ‡Montgomery | 5 | Seneca | 8 |
| ‡Chenango | 6 | Nassau | 3 | Steuben | 15 |
| Clinton | 2 | ‡New York | 378 | Suffolk | 9 |
| Columbia | 8 | Niagara | 15 | Sullivan | 2 |
| Cortland | 8 | Oneida | 24 | Tioga | 9 |
| Delaware | 5 | ‡Onondaga | 47 | Tompkins | 15 |
| ‡Dutchess | 15 | ‡Ontario | 18 | Ulster | 13 |
| Erie | 65 | Orange | 32 | Warren | 6 |
| Essex | 9 | Orleans | 8 | Washington | 16 |
| Franklin | 2 | ‡Oswego | 9 | Wayne | 19 |
| Fulton | 7 | Otsego | 9 | ‡Westchester | 35 |
| Genesee | 9 | Putnam | 4 | Wyoming | 9 |
| Greene | 3 | Queens | 10 | Yates | 6 |
| Herkimer | 6 | Rensselaer | 21 | | |

‡County Society.

## TOWN INDEX.


| Town. | County. |
|---|---|
| Adams | Jefferson |
| Akron | Erie |
| Albany | Albany |
| Albion | Orleans |
| Alexandria Bay | Jefferson |
| Almond | Allegany |
| Amsterdam | Montgomery |
| Antwerp | Jefferson |
| Arcade | Wyoming |
| Attica | Wyoming |
| Auburn | Cayuga |
| Avon | Livingston |
| Babylon | Suffolk |
| Baldwinsville | Onondaga |
| Ballston Spa | Saratoga |
| Batavia | Genesee |
| Batchellerville | Saratoga |
| Bath | Steuben |
| Belfast | Allegany |
| Belmont | Allegany |
| Big Flats | Chemung |
| Binghamton | Broome |
| Boonville | Oneida |
| Brewster | Putnam |
| Briar Hill | St. Lawrence |
| Brighton | Monroe |
| Brockport | Monroe |
| Brooklyn | Kings |
| Brownville | Jefferson |
| Buffalo | Erie |
| Caledonia | Livingston |
| Cambridge | Washington |
| Canandaigua | Ontario |
| Candor | Tioga |
| Canisteo | Steuben |
| Canistota | Madison |
| Canoga | Seneca |
| Canton | St. Lawrence |
| Cape Vincent | Jefferson |
| Carthage | Jefferson |
| Castleton | Rensselaer |
| Catlin | Chemung |

Cato ..... Cayuga
Cazenovia ..... Madison
Chatham ..... Columbia
Clarence Center ..... Erie
Chittenango ..... Madison
Clarendon ..... Orleans
Clayville ..... Oneida
Clifton Springs ..... Ontario
Clinton ..... Oneida
Clintondale ..... Ulster
Clyde ..... Wayne
Cohoes ..... Albany
Cold Spring ..... Putnam
Conklin Center ..... Broome
Cooperstown ..... Otsego
Copenhagen ..... Lewis
Coxsackie ..... Greene
Corfu ..... Genesee
Corning ..... Steuben
Cornwall-on-Hudson ... Orange
Cortland ..... Cortland
Crown Point ..... Essex
Cuba ..... Allegany
Dansville ..... Livingston
Deansboro ..... Oneida
De Kalb Junction..St. Lawrence
Delhi ..... Delaware
Deposit ..... Broome
De Ruyter ..... Madison
Dobb's Ferry ..... Westchester
Dundee ..... Yates
Dunkirk ..... Chautauqua
Eagle Bridge ..... Rensselaer
East Aurora ..... Erie
East Bloomfield ..... Ontario
East Greenbush ..... Rensselaer
East Hamilton ..... Madison
East Hamlin ..... Monroe
Easton ..... Washington
Elba ..... Genesee
Elbridge ..... Onondaga
Elizabethtown ..... Essex
Ellenville ..... Ulster
Elmira ..... Chemung
Essex ..... Essex
Etna ..... Tompkins
Fairport ..... Monroe
Farmer Village ..... Seneca
Fayetteville ..... Onondaga
Fishkill ..... Dutchess
Flushing ..... Queens
Fonda ..... Montgomery
Fort Ann..... Washington
Fort Edward ..... Washington
Fort Plain ..... Montgomery
Franklin ..... Delaware
Freeville ..... Tompkins
Fredonia ..... Chautauqua
Friendship ..... Allegany
Fulton ..... Oswego
Galway ..... Saratoga
Gasport ..... Niagara
Geneseo ..... Livingston
Geneva ..... Ontario
Ghent ..... Columbia
Glen Cove ..... Nassau
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Glenhead ..... Nassau
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Goshen ..... Orange
Gouverneur ..... St. Lawrence
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Greenbush ..... Rensselaer
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Greenwich ..... Washington
Groton ..... Tompkins
Hamburg ..... Erie
Hamilton ..... Madison
Hammondsport ..... Steuben
Hartwick ..... Otsego
Hempstead .....Nassau
Herkimer ..... Herkimer
Heuvelton ..... St. Lawrence
Holland ..... Erie
Homer ..... Cortland
Honeoye Falls ..... Monroe
Hoosick ..... Rensselaer
Hoosick Falls ..... Rensselaer
Hornellsville ..... Steuben
Horseheads ..... Chemung
Hudson ..... Columbia
Huntington ..... Suffolk
Italy Hollow ..... Yates
Ithaca ..... Tompkins
Jamaica ..... Queens
Jamestown ..... Chautauqua
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Johnsonville ..... Rensselaer

Johnstown ..... Fulton
Jordan ..... Onondaga
Keeseville ..... Essex
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Lebanon Springs ..... Columbia
Le Roy ..... Genesee
Liberty ..... Sullivan
Lily Dale ..... Chautauqua
Lima ..... Livingston
Little Falls ..... Herkimer
Little Valley ..... Cattaraugus
Liverpool ..... Onondaga
Livonia ..... Livingston
Livonia Station ..... Livingston
Lockport ..... Niagara
Logan ..... Schuyler
Long Island City..... Queens
Lowville ..... Lewis
Ludlowville ..... Tompkins
Lysander ..... Onondaga
Lyons ..... Wayne
Madison ..... Madison
Malone ..... Franklin
Mamaroneck ..... Westchester
Mannsville ..... Jefferson
Margaretville ..... Delaware
Marion ..... Wayne
Marcellus ..... Onondaga
Massena ..... St. Lawrence
Matteawan ..... Dutchess
Mechanicsville ..... Saratoga
Mecklenburgh ..... Schuyler
Medina ..... Orleans
Medway ..... Greene
Memphis ..... Onondaga
Mexico ..... Oswego
Middleport ..... Niagara
Middletown ..... Orange
Milbrook ..... Dutchess
Millport ..... Chemung
Modena ..... Ulster
Mohawk ..... Herkimer
Moriah ..... Essex
Moravia ..... Cayuga
Morris ..... Otsego
Mount Kisco ..... Westchester
Mount Vernon .... Westchester
Mt. Morris ..... Livingston
Naples ..... Ontario
Nelsonville ..... Westchester
Newark ..... Wayne
Newark Valley ..... Tioga
New Berlin ..... Chenango
New Brighton ..... Richmond
Newburgh ..... Orange
New Paltz ..... Ulster
New Rochelle .... Westchester
New Scotland ..... Albany
New York ..... New York
North Branch ..... Sullivan
North Brookfield ..... Madison
Niagara Falls ..... Niagara
North Granville ... Washington
North Tonawanda .... Niagara
North Tarrytown...Westchester
Norwich ..... Chenango
Norwood ..... St. Lawrence
Nunda ..... Livingston
Nyack ..... Rockland
Oaks Corners..... Ontario
Ogdensburg ..... St. Lawrence
Olean ..... Cattaraugus
Oneida ..... Madison
Oneonta ..... Otsego
Ontario.....Wayne
Oswego ..... Oswego
Otego ..... Otsego
Ovid ..... Seneca
Owasco ..... Cayuga
Owego ..... Tioga
Oxford ..... Chenango
Palmyra ..... Wayne
Panama ..... Chautauqua
Patchogue ..... Suffolk
Patterson ..... Putnam
Pavilion ..... Genesee
Peekskill ..... Westchester
Penfield ..... Monroe
Penn Yan ..... Yates
Perry ..... Wyoming
Phelps ..... Ontario
Philadelphia ..... Jefferson
Phœnix ..... Oswego
Pike ..... Wyoming
Pittsford ..... Monroe
Plattsburg ..... Clinton
Pleasantville ..... Westchester

Port Chester ..... Westchester
Port Crane ..... Broome
Port Gibson ..... Ontario
Port Jervis ..... Orange
Potsdam ..... St. Lawrence
Poughkeepsie ..... Dutchess
Randolph ..... Cattaraugus
Redwood ..... Jefferson
Rhinebeck ..... Dutchess
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Riverhead ..... Suffolk
Rochester ..... Monroe
Rome ..... Oneida
Reed Corners ..... Ontario
Rosendale ..... Ulster
Rondout ..... Ulster
Round Lake ..... Saratoga
Salamanca ..... Cattaraugus
Salisbury Center .... Herkimer
Salem ..... Washington
Salt Point ..... Dutchess
Sandy Hill ..... Washington
Saranac Lake ..... Franklin
Saratoga Springs ..... Saratoga
Saugerties ..... Ulster
Savannah ..... Wayne
Schenectady ..... Schenectady
Scott ..... Cortland
Seely Creek ..... Chemung
Seneca Falls ..... Seneca
Sherburne ..... Chenango
Shortsville ..... Ontario
Shrub Oak ..... Westchester
Silver Creek ..... Chautauqua
Sinclairville ..... Chautauqua
Sing Sing ..... Westchester
Skaneateles ..... Onondaga
Slate Hill ..... Orange
Sloansville ..... Schuyler
Smithville Flats ..... Chenango
Sodus ..... Wayne
South Butler ..... Wayne
South Byron ..... Genesee
South Greece ..... Monroe
South Hampton ..... Suffolk
Southold ..... Suffolk
Spencertown ..... Clinton
Springville ..... Erie
Spafford ..... Onondaga
Springwater ..... Livingston
Staatsburgh ..... Dutchess
Syracuse ..... Onondaga
Theresa ..... Jefferson
Ticonderoga ..... Essex
Tonawanda ..... ....Erie
Tottenville ..... Richmond
Trenton ..... Oneida
Troy ..... Rensselaer
Trumansburgh ..... Tompkins
Tully ..... Onondaga
Unadilla ..... Otsego
Union Springs ..... Cayuga
Union ..... Broome
Utica ..... Oneida
Victor ..... Ontario
Walden ..... Orange
Walton ..... Delaware
Walworth ..... Wayne
Wappingers Falls..... Dutchess
Warner's ..... Onondaga
Warsaw ..... Wyoming
Warwick ..... Orange
Washingtonville ..... Orange
Waterford ..... Saratoga
Waterloo ..... Seneca
Watertown ..... Jefferson
Waterville ..... Oneida
Watervliet ..... Albany
Watkins ..... Schuyler
Waverly ..... Tioga
Wayland ..... Steuben
Webster ..... Monroe
Weedsport ..... Cayuga
Wellsville ..... Allegany
Westbury Station ..... Queens
Westfield ..... Chautauqua
West New Brighton..Richmond
Westport ..... Essex
West Salamanca... Cattaraugus
Whitehall ..... Washington
West Winfield ..... Herkimer
White Plains ..... Westchester
Whitney Point ..... Broome
Williamsbridge ... Westchester
Williamson ..... Wayne
Wilson ..... Niagara
Wolcott ..... Wayne
Wyoming ..... Wyoming
Yonkers ..... Westchester
Yorkshire ..... Cattaraugus

## OPENINGS FOR PRACTICE.

| County. | Location. | Reference. |
|---|---|---|
| ALLEGANY, | Alfred, | DR. J. P. HUNTING, Alfred |
| CHAUTAUQUA, | Brocton, | DR. RIEGER, Dunkirk |
| " | Mayville, | DR. RICE, Jamestown |
| COLUMBIA, | Chatham, Philmont, | DR. H. C. VAN BUREN, 163 Halsey New York, Brooklyn. |
| DUTCHESS, | NewHackensack, | DR. A. C. HOWLAND, Poughkeepsie |
| ERIE, | Hamburg, | DR. W. D. YOUNG, 29 Park, Buffalo |
| FRANKLIN, | Malone, | DR. D. K. BELDIN, Malone |
| GREENE, | Athens, | DR. H. C. VAN BUREN, Brooklyn |
| LEWIS, | Lowville, | DR. M. H. BRONSON, Lowville |
| LIVINGSTON, | Avon, | DR. SKINNER, Le Roy |
| MONROE, | Scottsville, | DR. WALKER, West Henrietta |
| ONEIDA, | Clinton, | DR. I. DEVER, Clinton |
| ONONDAGA, | Manlius, | DR. L. B. RICHARDS, Oswego |
| OSWEGO, | Pulaski, | " " " |
| ORANGE, | Cornwall-on-Hudson, | MRS. R. S. BERGEN, "The Cedars" |
| STEUBEN, | Addison, | DR. W. D. YOUNG, 29 Park St., Buffalo |
| SUFFOLK, | Bay Shore, | DR. RAYMOND, Islip |
| | Westfield, N. J., | W. G. PECKHAM, ESQ., Westfield, N. J. |
| | Atlanta, Ga., | DR. SUSAN M. HICKS, Grand Building |

## ALBANY COUNTY.

*Annual Meeting, Albany, second Tuesday in January, President, E. G. Cox; Vice-President, G. E. Noble; Secretary and Treasurer, A. B. Van Loon.*

### ALBANY.

†‡Blessing, Elmer A., 93 Hudson Avenue.
*‡Carroll, Stephen H., 228 State.
*Cochrane, H. D., 175 Hamilton
*‡Cox, Edward G., 261 State.
*‡Cox, Frederick J., 109 State.
*‡Cox, Geo. A., 80 S. Swan.
*Dowling, J. Ivimey, 214 State.
Marshall, Dr. ———.
Gannett, Dr. ———.
*‡Gorham, G. E., 214 State.
*‡Hunting, Nelson, 155 Hamilton.
*‡McKown, Wm. J., 335 Hamilton
*‡Milbank, W. E., 111 State.
*‡Nead, W. M., 205 State.
†Schwilk, Elisha T., 105 Lark.
Skelton, Creighton W., 123 North Pearl.
*‡Van Loon, Arthur B., 50 Eagle.

### COHOES.

Mott, Albert, 105 Mohawk.
‡Campbell, Wm. M.

### NEW SCOTLAND.

‡Fitch, J. H.

### WATERVLIET.

Van Denbergh, Fred P., 220 23d.
Payne, Chas. O.

## ALLEGANY COUNTY.

*No Society.*

### ALMOND.

Farnum, Llewellyn, D.

**BELFAST.**

*Chamberlain, J. H.
Todd, W. S.

**BELMONT.**

*Hardy, Wm. J.
Paul, W. K.

**FRIENDSHIP.**

*Williamson, Bemsley.

**WELLSVILLE.**

Gish, C. L.

## BROOME COUNTY.

*Annual Meeting, Binghamton, third Wednesday in June. President, E. E. Snyder; Vice-Presidents, — Merrill, J. F. Roe; Secretary and Treasurer, W. F. Ward.*

**BINGHAMTON.**

‡Bates, J. B., 29 Arthur.
†‡Bailey, D. P., 41 Court.
Butterfield, Alfred J.
*‡Corwin, Elizabeth, 104 Main.
Dildine, Ida L., 116 Main.
‡Hand, Geo. F., 79 Court.
*‡Jenkins, Geo. H., 139 Main.
*‡Martin, Lynn A., 74 Exchange.
*‡McGraw, De Witt H., 3 and 4 Hagaman Building.
‡Mills, Mrs. Alice F., 19 Main.
*‡Proctor, Willis H., 25 Main.
Raymond, H. L., 25 Main.
*‡Roe, J. F., 25 Main.
*‡Snyder, E. E., 27 Main.
‡Stoutenburg, A. W., 27 Main.
*Turner, T. S., 231 Chenango.
*‡Ward, Charles A., 33 Court.
‡Ward, W. F., 33 Court.
‡Winters, C. S., 122 Court.

**CONKLIN CENTER.**

†‡Mandeville, F. de L.

**DEPOSIT.**

Graffin, J. C.
Leonard, H. K.

**PORT CRANE.**

Tiffany, J. T.

**UNION.**

Knapp, Theodore P.

**WHITNEY POINT.**

Pellette, A. H.

## CATTARAUGUS COUNTY.

*No Society.*

**LITTLE VALLEY.**

Barnes, F. G.

**OLEAN.**

*Hibbard, DeVere M., 112 Berry.
Jepson, Mary B.
Watts, T. E.

**GOWANDA.**

*Zwetsch, J. D., 23 Main.

**RANDOLPH.**

Babcock, A. H.

**SALAMANCA.**

Martin, O. S.
Bourne, Philip H.

**WEST SALAMANCA.**

Baker, Daniel P.

**YORKSHIRE.**

Sovereign, Baxter.

## CAYUGA COUNTY.

*No Society.*

**AUBURN.**

*Babbitt, Otis H., 178 Genesee.
Baker, A. E., 55 Franklin.
Bresee, Chas. H., 1 Cayuga.
*Frye, M. M., 167 Genesee.
*Gwynn, Charles A., 13 Grover.
*Gwynn, W. M., 14 Grover
Heartwell, W. B., 78 Genesee.
Hyatt, F. M., 49 E. Genesee.
Robinson, Robt. W., 30 Court.
Smith, Truman K., 173 Genesee.
Swift, Chas. L., 159 VanAnden.
Howland, Josephine.

**CATO.**

Evarts, Edgar S.

**MORAVIA.**

Cook, Wm. C.

**OWASCO.**

Ford, N. B.

**UNION SPRINGS.**

Alleman, J. J.
Smith, Oran W.

**WEEDSPORT.**

*‡Barnes, C. F.

## CHAUTAUQUA COUNTY.

*No Society.*

**DUNKIRK.**

*Rieger, Jos., 404 Central Ave.
Vosburg, W., 327 Lion.

**FREDONIA.**

*Couch, Asa S.
Dods, A. Wilson.
Landon, Elizabeth T.
Prish, J. W.

**JAMESTOWN.**

Lockwood, Benj. F.
Morgan, Laura.
Neville, Henry.
Ormes, F. D., 320 Main.
Rice, Alvin B., Main and Third.
Scott, John W.
Ward, Alva F.

**LILLY DALE.**

Hyde, E. C.

**MAYVILLE.**

Robbins, A. J.

**PANAMA.**

Young, A. D.

**SILVER CREEK.**

Cole, W. W.

**WESTFIELD.**

*Seymour, G. W.

## CHEMUNG COUNTY.

*No Society.*

**BIG FLATS.**

Davis, D. L.

**CATLIN.**

Thorn, Sarah Eddy.

**ELMIRA.**

*Adriance, F. W., 306 Lake.
Easton, James D.
*Eddy, Ermina C., 500 William.
*Gregory, G. W., 370 West Church.
*Howland, Reeve B., 306 Lake.
Jenks, R. B.
*Noble, E. H., 410 E. Church.
Parkhurst, G. H.
Platner, Marion M.

**HORSEHEADS.**

*De Camp, F. H.
Otis, Clark.

**MILLPORT.**

*McPherson, P. J.

**SEELY CREEK.**

Robbins, A. F.

## CHENANGO COUNTY.

*Annual Meeting, third Tuesday in January; Semi-Annual, third Tuesday in June. President, R. E. Miller; Secretary and Treasurer, F. E. Roper.*

**GREENE.**

*Guy, C. N.

**NEW BERLIN.**

‡Tuttle, Ella M.

**NORWICH.**

Roper, F. E.

**OXFORD.**

*‡Miller, R. E.
†‡Ganow, G. J.

**SHERBURNE.**

‡Little, Wm.

## CLINTON COUNTY.

**PLATTSBURGH.**

Farnsworth, F. S.
*Low, Elliot C., Oak, corner Brinkerhoff.

## COLUMBIA COUNTY.

*No Society.*

**CHATHAM.**

Clark, Mary.
Mosher, Charles L.

**GHENT.**

Green, J. H.

**HUDSON.**

*Cook, C. P.
Tracy, A. M.

**KINDERHOOK.**

Green, James.

**LEBANON SPRINGS.**

*Van Buren, B. L.

**SPENCERTOWN.**

Mesick, J. C.

## CORTLAND COUNTY.

*No Society.*

**CORTLAND.**

Johnson, H. P.
Nash, E. B.
Santee, E. M.
Spalding, Julia H.

**HOMER.**

Potter, Leman W.
Goodell, R. A.
*Pratt, L. M.

**SCOTT.**

*Ball, Halsey J.

## DELAWARE COUNTY.

*No Society.*

**DELHI.**

*Schumann, Carl.

**FRANKLIN.**

Foote, J. H.

**MARGARETVILLE.**

Telford, John W.

**WALTON.**

Mowbray, J. L.
St. John, A. H.

## DUTCHESS COUNTY.

*Annual Meeting, Poughkeepsie, first Tuesday in October. Pres't, H. Reed Hawley; Vice-Prest., J. H. Otis; Sec. and Treas., A. L. Peckham.*

**FISHKILL.**

†Embley, Thomas W.

**MATTEAWAN.**

Dawson, J. G.

**MILLBROOK.**

‡Jacobus, S. J.

**POUGHKEEPSIE.**

*‡Case, Walter R., 239 Mill.
‡Howland, Anna C., 18 South Hamilton.
*‡Lane, Chas E., 280 Mill.
*‡Otis, John C.
‡Otis, John H.
†Peckham, A. L.
Williamson, P. T.

**RHINEBECK.**

Asher, Rutson E.
‡Godell, J. L.

**SALT POINT.**

‡Angel, Milton H.

**STATTSBURG.**

*‡Hawley, H. Reed.

**WAPPINGER'S FALLS.**

‡Baxter, William.

## ERIE COUNTY.

*No Society.*

### AKRON.

Parker, Frank D.

### BUFFALO.

Babcock, C. W., 151 Allen.
Bæthing, H., 530 Pennsylvania.
*Beals, Herbert, 176 Franklin.
Blighton, W. V-R., 1067 Grant.
Bodenbender, Edward G., 660 Walden Ave.
Bodenbender, N. W., 804 Jefferson.
Broardt, Peter, 394 Adams.
Brown, Alice B., 26 Irving Pl
Bull, Alex. T., 184 Franklin.
Carter, P. L., 35 Lafayette Ave.
*Chadwick, J. G., 382 Franklin.
*Cook, J. T., 636 Delaware Ave.
Crandall, W. A., 109 South Division.
*Critchlow, Geo. R., 505 Norwood Avenue.
Curtis, A. M., 780 W. Ferry.
Dean, D. A., 89 Riley.
*Decker, W. M., 242 Ashland.
*Erb, Peter, 32 and 34 Palace Arcade.
Fisher, E. A., 1038 Fillmore Avenue.
*Foster, Hubbard A., 3 St. John's Place.
Frost, H. C., 212 Delaware Avenue.
Groesbeck, Fred'k B., 597 Elmwood Avenue.
Hadley, W. A. M., 63 West Huron.
Halbert, J. S., 459 Franklin.
Hussey, E. P., 493 Porter Ave.
*Kenyon, W. B., 13 E. Swan.
*Lewis, Fred. D., 188 Franklin.
*Lewis, F. Park, 454 Franklin.
Lewis, G. W., Jr., 311 Delaware Avenue.
Linquist, M. F., 497 Elmwood Avenue.
Long, W. E., 892 Ellicott Square.
McCrea, Philip A., 448 Franklin.
McGill, W. D., 296 S. Division.
Marcy, W. H., 1148 Main.
*Martin, Truman J., 140 North.
*Maycock, B. J., 33 Allen.
*Miller, John, 48 St. John's Pl.
Morris, Sarah, 2079 Main.
*Moseley, G. T., 202 Delaware Avenue.
McClellan, A. I., 72 York.
Parmenter, W. L., 931 Prospect Avenue.
Reed, Mark E., 24 Como Ave.
Roberts, Burt B., 58 Palace Arcade.
Root, Reuben M., 40 Krettner.
Salter, A. E., 20 Edna Place.
Seaman, C. W., 232 Hoyt.
*Seitz, F. B., 33 N. Pearl.
Spilsbury, F. C., 502 Niagara.
*Stearns, G. R., 201 Linwood Avenue.
*Stumpf, Daniel B., 693 Ellicott.
Wage, John F., 414 Seneca.
*Wilcox, DeWitt G., 597 Elmwood Avenue.
Wild, Geo. W., 345 Main.
Wilder, Rose C., 388 W. Ferry.
Young, Wm. D., 29 Park.

### CLARENCE CENTER.

Lehman, J. S.

### GOWANDA STATE HOMOEOPATHIC HOSPITAL.

*Adams, G. F.
*Arthur, D. H.
*Potter, Clarence A.

### EAST AURORA.

Mitchell, A. L.

**HAMBURG.**

Barnes, Francis.

**HOLLAND.**

Noble, W. A.

**SPRINGVILLE.**

Caulkins, Frank.

Young, Chas. H.

**TONAWANDA.**

Simpson, John R.

## ESSEX COUNTY.

*No Society.*

**CROWN POINT.**

Eaton, Erwin R.

**ELIZABETHTOWN.**

Wasson, T. A.

**ESSEX.**

Chase, Edwin R.

**JAY.**

Toby, C. McV.

**KEESEVILLE.**

Pope, Willis G.

Severance, Karl.

**MORIAH.**

Powell, George W.

**TICONDEROGA.**

Bond, George W.

**WESTPORT.**

*Shattuck, J. W. M.

## FRANKLIN COUNTY.

**MALONE.**

Belding, D. K.

**SARANAC LAKE.**

*Hallock, J. Henry.

## FULTON COUNTY.

(‡*Montgomery County Society.*)

**GLOVERSVILLE.**

Bissell, D. A.

*‡Eisenbrey, E. H.

*‡Garnsey, W. S., 93 N. Main.

*‡Hill, Emily L.

‡Knott, Harriet A.

Tuck, Arthur E.

**JOHNSTOWN.**

*‡Walrad, C. B.

## GENESEE COUNTY.

*No Society.*

**ELBA.**

Lewis, J. M.

**BATAVIA.**

Baker, John W., 5 Bank. *Hutchins, H. S., 215 E. Main.
*LeSeur, J. W., 207 E. Main.

**CORFU.**

Carrier, Eugene W.

**LE ROY.**

*Skinner, Scott W., 12 Myrtle. Skinner, S. W., Jr.

**PAVILION.**

Sweeting, S. C.

**SOUTH BYRON.**

Whiton, Alpha M.

## GREENE COUNTY.

*No Society.*

**CATSKILL.**

*Vincent, Stanley, 262 Main.

**COXSACKIE.**

Klaer, Clarence.

**MEDWAY.**

Collins, D. E.

## HAMILTON COUNTY.

(No Homœopathist.)

## HERKIMER COUNTY.

(‡*Oneida County Society.*)

**HERKIMER.**

‡Kern, E. G.

**LITTLE FALLS.**

*‡Brainard, L. L.

**MOHAWK.**

Landt, Wm.

**SALISBURY CENTER.**

Wood, E. Hamlin.

**WEST WINFIELD.**

Spencer, H. J. Stevens, J. H.

## JEFFERSON COUNTY.

*Annual Meeting, Watertown, third Wednesday in November. Prest., J. E. Ryan, Vice-Prest., G. A. Gifford; Sec. and Treas., R. F. Gates.*

**ADAMS.**

*‡Nickelson, W. H.

**ALEXANDER BAY.**

Campbell, E. E. Cole, J. D.

**ANTWERP.**

Flint, R. J.

**BROWNVILLE.**

‡Gates, R. F.

**CAPE VINCENT.**

Bushnell, H. N.

**CARTHAGE.**

‡Simonds, C. A.
‡Simonds, E. A.

**MANNSVILLE.**

‡Hibbard, G. C.

**PHILADELPHIA.**

Ryan, M. M.

**REDWOOD.**

‡Ryan, J. E.

**THERESA.**

*‡Santway, F. L.
Dresser, E. Dell.

**WATERTOWN.**

Adams, M. M.
‡Bartlett, Geo. W.
Chattaway, A. D.
Flint, Chas. B.
‡Gifford, G. A.
Laird, W. T.
Smith, G. W. B.
‡Farmer, G. S.

## KINGS COUNTY.

*Annual Meeting, 44 Court St., Brooklyn, second Tuesday in January. Prest., Orando S. Ritch; Vice-Prest., W. H. Aten; Sec., E. Rodney Fiske; Treas., C. W. Smith; Necrologist, B W. Bierbauer.*

**NEW YORK, BROOKLYN BOROUGH.**

*‡Allen, Emma T. P., 310 Clermont Avenue.
*‡Allen, Herbert C., 310 Clermont Avenue.
†‡Aten, Wm. H., 100 Greene Ave
*‡Avery, E. W., 16 Hancock.
†‡Ayres, Rebecca J., 806 Green Avenue.
Badanes, Ida, 365—14th.
*‡Baker, Jennie v. H., 512 Bedford Avenue.
Barden, Wm. W., 88—2nd Pl.
Barnes, Roxana K., 161 Garfield Place.
Barnum, Fred'k L., 798 Bedford Avenue.
*‡Baylies, B. L'B., 418 Putnam Avenue.
†‡Bedford, E. R., 814 Marcy Ave.
Belden, Chas. K., 379 Gates.
*‡Bennet, G. H. R., 21 S. Portland Avenue.
*‡Bierbauer, B. W., 85 Pierrepont.
‡Birdsall, Edgar, 1038 Bedford.
‡Bishop, Gertrude G., 475 Madison.
Blackman, Mrs. Lora, 519 Clinton Avenue.
*‡Blackman, W. W., 519 Clinton Avenue.
*‡Bolan, L. W., 413a Quincy.
Bond, Frank, 27 Schermerhorn
*‡Bonnell, Chas. L., 3 Hanson Place.
Boocock, Robert, 175 Woodruff.
‡Breck, William B., 235 Garfield Place.
‡Brinkerhoff, A. S., 544 Monroe
‡Bronson, Chas. H., 438 Pacific.
†‡Broughton, L. D., Jr., 418 Madison.
Brown, Annie M., 155 Halsey.
‡Brown, Charles A., 155 Halsey.
*‡Bryant, W. C., 64 Greene Ave.
*Bulmer, Geo. W., 1210 Bushwick Avenue.
‡Burnette, Katherine D., 486 Bedford Avenue.

*‡Burnham, Clark, 182 Clinton.
*‡Butler, W. M., 507 Clinton Avenue.
†‡Buys, Thos. A., 1483 Bedford Avenue.
*‡Caldwell, Frank E., 151 Henry.
†‡Cameron, Elizabeth W. M., 23 Seventh Avenue.
Campbell, Alice B., 552 McDonough.
Campbell, John B., 552 McDonough.
‡Cardozo, Jacob L., 223a Monroe
‡Carman, Margaret A., 57 Tompkins Avenue.
Carr, H. L., 856 Lafayette Ave.
Casselberry, J. L., 109 Cumberland.
*‡Cassidy, Georgia A., 703 Nostrand Avenue.
*Chamberlin, W. T., 127 7th Av.
*‡Chapin, Edward, 21 Schermerhorn.
‡Chaplain, F. T., 324 Sumner Avenue.
‡Clark, G. F., 515 Decatur.
†‡Clarke, M. Elizabeth, 8 Lafayette Avenue.
Clark, Homer, 10 New York Avenue.
‡Close, Stuart, 209 Hancock.
‡Coddington, Fannie R., 16 Ormond Place.
‡Cornell, Geo. B., 137 Seventh Avenue.
†‡Cort, Lottie A., 89 Division Avenue.
Crane, Chas. F., 565 Quincy.
*‡Denison, R. N., 55 Eighth Ave.
Dewey, Geo. A., 519 Halsey.
†‡Devol, Edmond, 114 Nassau.
Deyo, J. T., 364 Ninth.
‡Diehl, W., Jr., 150 Cornelia.
*‡Doty, George H., 245½ Cumberland.
Durrin, Wm. C., 1038 Bedford Avenue.
Dunlevy, Mrs., 166 DeKalb Avenue.
Durkee, Jeannette R., 197 Harrison.
Dowling, Geo. B., 5 Ave. A.
Eaton, J. Albro, 134 Lafayette.
Eden, Samuel, 1340 Bushwick Avenue.
*‡Elliot, Amos H., 480 Monroe.
Ermentraut, Henry, 324 S. 5th.
Ermentraut, J. P., 134 Hendrix
†‡Fawdray, J. W., 242 Clermont Avenue.
‡Feckles, Mary Fish, 232 Tompkins Ave.
‡Fincke, Bernhard, 122 Livingston.
*‡Fiske, E. R., 488 Nostrand Ave
*‡Fiske, W. M. L., 484 Bedford Avenue.
‡Gerrie, James, 357 Halsey.
*‡Given, James B., 359 Eleventh.
Goddard, Abbie E., Classon and St. Mark's.
*‡Gorton, D. A., 137 Clinton.
Greene, Julia M., Classon and St. Mark's.
‡Hadley, C. H., 55th, near New Utrecht Avenue.
‡Hale, Harriet W., 171 McDonough.
Hamilton, C. T., 103 Park Pl.
Hanford, S. C., 178 S. 5th.
Hanford, Wm. H., 84 Lee Ave.
*‡Hasbrouck, Everitt, 369 Ninth.
‡Heywood, Abner, 426 Franklin Avenue.
‡Hobby, Ada T., 944 Marcy Ave
Hopke, F. Edward, 109 Cumberland.
‡Hopper, M. T., 63 S. Oxford.
‡Houghton, B. L., 616 St. Mark's Avenue.
‡Hudson, W. T., 218 Livingston
Hunt, Ida B., 363 Gates Ave.
Hunt, John A., 212 Livingston.
†‡Iler, G. H., 237 McDonough.
Jarrett, A. R., 91 Halsey.
*‡Jeffery, G. C., 343 Jefferson Avenue.
‡Jenks, F. Percy, 419 Ninth.

Jennings, Ella A., 12 Nevins.
*‡Johnston, C. L., 467 Vanderbilt Avenue.
*‡Kastendieck, J. T. W., 149 Keap.
Keep, J. Lester, 460 Clinton Avenue.
‡Knapp, H. J., 287 South 5th.
Lanzer, Lewis, 404 S. 3d.
‡Lassen, Helene S., 152 Henry.
‡Latimer, W. C., 351a Clinton.
*‡Lauer, Chas. F., 248 Emerson Place.
*‡Lawrence, J. B., 289 Ninth.
*‡Lazarus, Geo. F., 6 Caton Ave.
Leverson, M. R., 96th, near Shore Road.
‡Lines, Mary L., 344 Washington Avenue.
Lines, O. T., 344 Washington Avenue.
*‡Lloyd, R. I., 296 Forty-seventh.
†‡Love, Wm. L., 1188 Dean.
Lowe, Evelyn, 944 Marcy Ave.
*‡Lutze, F. H., 212 Keap.
Martin, Kenneth B., 123 Prospect.
‡Martineau, S. Catherine, 309 Clinton.
Martino, R. R., 792 Madison.
McCune, Olive F., 53 Orange.
†‡McLenathan, W. H., 101 Division Avenue.
Mead, Byron E., 443 Pacific.
Metcalf, J. W., 71 Stone Ave.
‡Minshull, Frances E., 130 Halsey.
*‡Minton, Henry B., 165 Joralemon.
*‡Moffat, John L., 1136 Dean.
‡Monmonier, J. L., 480 Classon Avenue.
†‡Moon, W. W., 184 Macon.
*‡Muncie, E. H., 119 Macon.
*‡Muncie, Mrs. L. H., 119 Macon
Newcomb, Geo. W., 191 Adelphi.
‡Nichols, George, 306 Monroe.
*‡Nottage, Rachel, 669 Macon.
*‡Ogden, G. S., 24 Kenilworth Pl
‡Onderdonk, Emma, 104 South Elliott Place.
‡Pallister, Stanley W., 376 Madison.
Patton, Jas. H., 77 Lexington.
‡Palmer, A. J., 90 Hancock.
†‡Palmer, G. H., 92 Hancock.
Palmer, Warren B., 360 Hancock.
Perveil, A. C., 14 Hancock.
*‡Pierron, H. J., 438 Greene Ave.
‡Pierson, W. E., 162 Macon.
‡Pierson, W. H., 101 McDonough.
Pinkham, Charles B., 109 Cumberland.
*‡Preston, H. G., 54 Greene Ave.
Reynolds, Harry C., 109 Cumberland.
Rankine, Isabella M., 626 Willoughby Avenue.
‡Richards, Mary E., 108 S. 9th.
‡Richardson, B. M., 151 Milton.
‡Richter, H. W., 54 Sterling Pl.
von Rigelman, Mrs. Laura M. Long, 866 Driggs.
*‡Rink, Walter S., 295 Halsey.
‡Risley, Frank E., 355 Jefferson Avenue.
*‡Ritch, A. M., 711 Putnam Ave.
*‡Ritch, Orando S., 337a Macon.
‡Robinson, Maria M., 156 Macon.
*‡Robinson, Nathaniel, 89 Halsey
Robinson, W. B., 245 Euclid.
*‡Rockefeller, H. O., 152 Jerome
Rukenbrod, W. E., 14 South Elliot Pl.
‡Rose, H. W., 98 Hooper.
*Russell, J. E., 1032 Bedford Avenue.
*Schall, J. H., 141 St. Mark's Avenue.
*‡Schenck, H. D., 241 McDonough.
‡Schlegel, Louise, 472 Willoughby Avenue.
*‡Searle, W. S., 62 Clark.
‡Seeley, W. W., 44 Hanson Pl.
‡Shattuck, H. P., 112 Reid Ave.

Shea, Jos. M., 651 Fulton.
††Shrewsbury, W. J., 238 Keap.
*‡Simmons, D., 1188 Dean.
‡Simon, S. H., 195 Garfield Pl.
Sisson, Mabel C., Classon and St. Mark's.
‡Slee, H. C., 277 Hewes.
‡Smith, A. T., 699 Greene Ave.
‡Smith, Clara Louise, 264 Stuyvesant.
‡Smith, G. H., 921 Greene Ave.
‡Smith, Sidney E., 77 Arlington Avenue.
Spooner, E. H., 561 Macon.
‡Stafford, Fred E., 142a Putnam Avenue.
*‡Stewart, J. A., 1030 Bedford Avenue.
‡Stiles, S. E., 51 Greene Ave.
††Stolz, Rosalie H., 778 Putnam Avenue.
Stolz, Mary, 778 Putnam Ave.
Straley, May W., 282 Halsey.
*‡Street, H. E., 98 Brooklyn Avenue.
Struebel, Julius, 495 Hart.
‡Sutton, Jno. J., 514 Willoughby Avenue.
*‡Talmage, Samuel, 22 Schermerhorn.
Terhune, Walter S., 299 Reid Avenue.
‡Thompson, J. M., 382 Clinton.
‡Turton, M. Louise, 519 Greene Avenue.
††Underhill, A. E., 465 Hancock.
‡Van Arnam, Mrs. A. B., 426 Franklin Avenue.
*Van Buren, Hattie C., 163 Halsey.
Van Kleek, J. H., 707 Union.
‡Van Mater, G. G., 354 Macon.
Van Schoonhoven, C. S., 1060 Lafayette Avenue.
Van Tine, Margaret H., 214 Greene.
‡Von der Lühe, Amelia D. F., 801 Driggs Avenue.
*‡Von der Lühe, Augustus, 245 Hooper.
††Walmsley, R. F., 491 Putnam Avenue.
Walters, Chas. A., 111 Milton.
Wamsley, W. E., 797 Putnam Avenue.
*‡Warner, Alton G., 19 Schermerhorn.
‡Watson, J. L., 257 Schermerhorn.
‡Wemmel, A. A., (Ecl. Lic.) 2600 Atlantic Ave.
West, Helen, St. Mark's and Classon.
*‡Wiggins, T. C., 12 Verona Pl.
‡Williams, F. B., 583 Bedford Avenue.
‡Willis, Clinton, 494 Putnam Avenue.
Wilson, C. H., 360 Tompkins Avenue.
*‡Willis, H., Jr., 467 Monroe
*‡Winchell, W. B., 137 Berkeley Place.
‡Woolley, Charlotte H., 676 Prospect Pl.
*‡Wright, Justus G., 363—11th.

## LEWIS COUNTY.

(‡*Jefferson County Society.*)

**COPENHAGEN.**

Hall, C. B.

**LOWVILLE.**

‡Bronson, Miles H.

## LIVINGSTON COUNTY.

*No Society.*

**AVON.**

Allen, Cyrus.

**CALEDONIA.**

*Borden, G. T.
Cole, D. D.

**DANSVILLE.**

*Andrews, B. P., 103 Main.

**GENESEO.**

*Page, Roy A.
Southall, E. W.

**LIMA.**

Mackenzie, John A.

**LIVONIA.**

Bettis, J. T.

**LIVONIA STATION.**

Trimmer, W. S.

**MOUNT MORRIS.**

Leach, A. E.

**NUNDA.**

*Ostrander, P. M.

**SPRINGWATER.**

Whitfield, H. A.

## MADISON COUNTY.

*Annual Meeting, Oneida, fourth Tuesday in June. Prest., B. R. Gifford; Vice-Prest., E. N. Coon; Sec. and Treas., J. T. Wallace.*

**CANASTOTA.**

Deuel, W. E.

**CAZENOVIA.**

‡Bass, E. C.

**CHITTENANGO.**

*‡Deuel, W. E.

**DE RUYTER.**

‡Coon, E. N.

**EAST HAMILTON.**

‡Palmer, G. B.

**HAMILTON.**

*‡Gifford, G. L.
‡Willcox, G. W.

**MADISON.**

‡Gifford, Barton R.

**NORTH BROOKFIELD.**

York, G. T.

**ONEIDA.**

‡Wallace, J. T.
Randall, E. G.

## MONROE COUNTY.

*Annual Meeting, Rochester Homœopathic Hospital, third Tuesday in January. Prest., H. W. Hoyt; Vice-Prest., L. L. Button; Sec., L. J. Sanders. Treas., H. A. Anderson.*

**BRIGHTON.**

Wheeler, J. P.

**BROCKPORT.**

Winne, F. A.

**EAST HAMLIN.**

Darrow, S. W.

**FAIRPORT.**

*‡Clapp, W. F.
‡Price, George S.
‡Tubbs, J. F.

**HONEOYE FALLS.**

Brown, D. G.
*‡Otis, Chas. F.

**PENFIELD.**

Humphrey, N. M.

**PITTSFORD.**

*‡Doane, W. H.
Johnson, W. W.

**ROCHESTER.**

*‡Adams, Myron H., 821 Granite Building.
*‡Adams, R. A., 46 N. Fitzhugh.
‡Anderson, H. A., 391 West Avenue.
*‡Bachman, G. A., 167 South Avenue.
Biegler, J. A., 58 Clinton Ave. South.
*‡Bissell, E. J., 75 S. Fitzhugh.
Brownell, J. R., 224 Alexander.
Brownell, W. G., 122 North.
*‡Buell, Jesse W., 41 Clinton Avenue, South.
Bunnell, L. M., Jr., Hahnemann Hospital.
‡Button, L. L., 44 Clinton Ave., South.
†‡Carman, W. B., 23 Upton Park
Chaffee, D. J., 8 Clinton Ave.
†‡Chamberlayne, Mrs. Louise F., 16 State.
*‡Clapp, C. R., 427 Hayward Ave.
*‡Collins, N. M., 43 East Ave.
Cox, J. T., 333 Clinton Avenue, North.
Curtiss, W. H., 36 Clinton.
Dake, W. E., 271 Monroe Ave.
Dixon, W. Walker.
Earle, E. W., 55 Monroe Ave.
*‡Fowler, W. P., 63 Clinton Ave., South.
Fritz, A. R., 28 Draper.
*‡Graham, M. E., 700 South Ave.
Grant, R. C., 279 South Ave.
*‡Haywood, G. M., 48 Clinton Avenue, South.
*‡Haywood, Julia F., 612 West Avenue.
Hermance, A. C., 611 St. Paul.
Hermance, S. G., 568 Plymouth Avenue.
Hoard, V. A., 637 Main, East.
*‡Hoyt, Herbert W., 75 S. Fitzhugh.
‡Hoyt, Mrs. Mary M., 10 Westminster Road.
Johnson, W. W., 20 Triangle Building.
*‡Keegan, W. A., 40 Clinton Avenue, South.
*‡Kellogg, C. M., 42 Clinton Avenue, North.
*‡Lee, J. M., 121 Lake Ave.
*MacCallum, John H., 408 Monroe Avenue.
McCullough, Alice S., 19 Laburnam St.
Morton, Pauline, 27 Clinton Avenue, South.
*‡Neefus, P. W., 124 East Ave.
Norman, A. J., 186 Alexander.
*‡Parsons, Thomas, 213 Alexander.
Perrine, C. W., 76 Clifton.
*Phillips, R. F., 21 Park Ave.
Proctor, J. C., 29 Buckingham
*‡Rambo, W. S., 41 Sophia.
*‡Ricker, Mrs. M. S., 58 Lorimer
Ross, E. V., 279 Jefferson Ave.
*‡Sanders, L. J., 421 Monroe Ave
Sayles, Emma S., 13 Park Ave.
Schnell, A. E.
Seeley, J. E., 138 Main, East.

‡Shepard, H. G., 72 N. Clinton.
Skinner M. H., Hom. Hospital.
*‡Smith, F. R., 400 Main, East.
*‡Snow, S. R., 267 Alexander.
*‡Spencer, T. D., 24 S. Union.
‡Stillwell, F. W., 32 University Avenue.
*‡Sumner, C. R., 33 Clinton Avenue, South.
Thomson, G. M., 246 East Ave.
Thorpe, J. L., Hom. Hospital.
*‡Thurber, T. J., 157 Plymouth Avenue.
‡Tretton, J. K., 239 Lake Ave.
‡Van Allan, R. A., 234 Monroe Avenue.
Wadsworth, Robert, 176 State.
White, B. R., Hom. Hospital.
Willis, F. L. H., 243 Alexander
†Winans, W. W., Hom. Hosp.
*‡Wolcott, E. H., 57 Union S.

**SCOTTSVILLE.**

Archer, D. E.

**SOUTH GREECE.**

*‡Buell, E. S., (Lic.)

**WEBSTER.**

††Whittleton, E. J.

## MONTGOMERY COUNTY.

*Annual Meeting at Fonda, second Tuesday, Quarterly Meetings. Prest., Wm. M. White; Vice-Prest., Louis Faust.*

**AMSTERDAM.**

*‡Frazier, L. A., 124 Division. ‡Hicks, H. M.
‡White, Wm. M., 26 Pearl.

**FONDA.**

Foster, A. B.

**FORT PLAIN.**

‡Zoller, Wm.

## NASSAU COUNTY.

*No Society.*

**GLEN COVE.**

*Foster, W. E.

**HEMPSTEAD.**

Lount, Robert, 79 Fulton.

**GLEN HEAD.**

Freeman, Geo. L.

## NEW YORK COUNTY, (MANHATTAN AND BRONX BOROUGHS.)

*Annual Meeting, second Thursday in December, at Carnegie Hall. President, F. H. Boynton; Vice-Prest., Irving Townsend; Sec., J. Perry Seward; Treas., C. S. Macy; Librarian, Chas. Ver Nooy.*

*‡Allan, Arthur G., 14 W. 32d.
††Allen, J. Wilford, 110 W. 12th.
*‡Allen, Paul, 3 E. 48th.
*‡Allen, T. F., 3 E. 48th.
*‡Ambler, J. Edgar, 134 E. 19th.
††Andrew, R. M., 1730 Washington.
Arcularius, P. E., 104 W. 44th.
††Arschagouni, John, 743 Lexington Ave.

Atkins, L. R., 108 W. 96th.
Austin, A. E., 17 E. 66th.
Badaurs, Ida, 222 E. Broadway
††Bagg, C. L., 67 W. 45th.
Baker, C. M., 43 Sixth Ave.
‡Baker, C. R., 144 Convent Ave.
Baker, Daniel J., Blackwell's Island.
*‡Baldwin, J. G., 8 East 41st.
‡Bartlett, G. W., 27 E. 111th.
Baruch, Solomon, 1135 Lexington Avenue.
Bassett, J. S., 11 West 31st.
‡Beals, M. B., 127 E. 116th.
Beckley, Wm. H., Blackwell's Island.
Beckwith, Seth. R., 170 Fifth.
Beckwith, Tifft., 170 Fifth.
‡Bennett, J. A., 4 Irving Place.
*‡Berghaus, A., 138 East 65th.
*‡Beyea, J. L., 217 Second Ave.
††Bickford, Lydia A., 45 W. 39th
Biegeleisen, Nathan, 287 Third Avenue.
‡Bigelow, A. J., 163 E. 106th.
Bingham, A. H., 113 W. 87th.
*‡Bishop, Wm. H., 56 W. 48th.
Bissell, Sarah E., 207 W. 14th.
Black, Caroline L., 114 W.123d
Blakeman, J. L., 1977 Seventh Avenue.
*‡Bond, Mary E., 122 Lexington Avenue.
Bonnewitz, Orlando R., 172 West 126th.
Bonschur, G. A., 141 W. 21st.
*‡Boyle, C. C., 49 W. 37th.
*‡Boynton, F. H., 36 West 50th.
Bradsworth, John H., 449 Second Ave.
Bray, Charles S., 69 West 99th.
‡Bren, M. R., 1949 Seventh Ave
Broeser, Henry E., 63rd and Eastern Boulevard.
‡Brown, G. C., 56 West 45th.
*‡Brown, M. Belle, 135 W. 34th.
Bryson, Louise F., 66 West 53d
††Buchanan, T. D., 328 W. 24th.
*‡Buchholz, Louise Z., 73 St. Mark's.
Burd, Emma deL., 456 Manhattan.
Burdick, Mrs. Alice H., 339 W. 34th.
Campbell, Annie S., Woody Crest Ave. and 163d St.
‡Campbell, C. E., 314 East 18th.
‡Cannon, M. D., 147 W. 128th.
*‡Carleton B. G., 75 W. 50th.
‡Carleton, E., 62 W. 49th.
Carpenter, Fred. A., 341 W. 23d
Chamberlin, G. W., 26 West 129th.
‡Chapman, A. E., 115 W. 44th.
*Charles, Emily C., 51 W. 127th.
*‡Chase, J. O., 214 East 53d.
Chattaway, A. D., 713 E. 138th
‡Church, Eloise I., 41 W. 94th.
Church, Charles A., 41 W. 26th
*‡Clark, B. G., 162 West 122nd.
Clark, C. C., Blackwell's Island
Clemons, Carl, 322 East 19th.
Clock, Sarah A., 5 W. 65th.
Coles, H. L., 83 W. 104th.
Cochrane, G. D., 48 W. 57th.
Cooke, Mrs. H. N. F., 41 W. 65th.
‡Cooley, Helen, 110 W. 84th.
*‡Cornell, C. W., Hotel St. Andrew.
‡Cossart, A. B., 1378 Lexington Avenue.
Crompton, Chas. W., 1894 Boston Avenue.
*‡Crump, W. G., 693 Madison Avenue.
Dale, Marian A., 33½ W. 131st.
*‡Danforth, L. L., 59 W. 52d.
Daniels, J. L., 165 West 126th.
*Davies, Thos. F., 359 W. 116th.
Davis, Jane C., 138 E. 48th.
*‡Davis, J. E. L., 743 Madison Avenue.
Davis, T. F., Flower Hospital.
.*‡Deady, Chas., 110 West 48th.
*‡Dearborn, H. M., 146 W. 57th.
Decker, J. W., 353 W. 57th.
*‡Delabarre, W. E., 244 Central Park.
*‡Demarest, J. H., 59 W. 156th.

*‡Deschere, Martin, 334 W. 58th.
Dieffenbach, W. H., Eastern Boulevard and 63rd St.
*‡Dillingham, T. M., 8 W. 49th.
*‡Dillow, George M., 57th and Broadway.
‡Donoghue, Anna F., 400 W. 57th.
*‡Doughty, F. E., 512 Madison Avenue.
*‡Dowe, F. Le C., 332 Alexander Avenue.
Dowkontt, H. G., 121 E. 45th.
Dowling, George B., 32 E. 30th
*‡Dowling, J. W., 116 W. 48th.
*Drury, Alfred, 457 W. 147th.
‡Dryer, F. H., 747 E. 176th.
Dunham, Mrs. E., 19 W. 81st.
†‡Dunlevy, Rita, 328 W. 57th.
‡Durrie, G. B., 103 W. 54th.
Durkee, Jeanette R., 240 West 52nd.
Eden, J. H., St. James, near Aqueduct Avenue.
Edmonstone, Elizabeth, 40 W. 25th.
†‡Edwards, Mary L., 19 W. 46th.
*‡Eife, Arthur F., 175 W. 10th.
Eife, Francis, 335 E. 18th.
Elebash, Carl P., 118 E. 19th.
Elebash, Clarence S., 118 East 19th.
Elmendorf, T. C., 344 E. 42d.
Ely, L. W., 114 W. 86th.
‡Emery, Mary E., 24 W. 45th.
‡Ermentraut, J. P., 33 Seventh Street.
Evans, C. V. S., 255 W. 122nd.
*‡Ferrier, Jas. M., 166 E. 111th.
Finch, Joseph, 106 W. 44th.
Fleming, Laura M., 57 W. 45th
Fleming, W. L., 174 St. Nicholas.
Fletcher, Addison C., 353 W. 32nd.
*‡Fralick, W. G., 778 Madison Avenue.
*‡Franklin, E. D., 325 W. 14th.
‡Gage, Mary E., 19 W. 46th.
Garrison, H. W., 154 E. 86th.
*‡Garrison, J. B., 111 E. 70th.
Goodrich, F. W., 245 E. 84th
Gillespie, C. S., 266 Monroe.
Gennerich, Chas., 154 E. 62d.
Gilbert, C. E., 343 W. 23d.
Gilbert, Mrs. M. H., 15 E. 11th
‡Gillingham, H. P., 787 Park Avenue.
‡Goodrich, S. W., 507 W. 152d.
*Gore, Jennie E., 1145 Park Ave
Gray, R. B., 202 W. 81st.
Graffin, J. C., Hahnemann Hospital.
‡Graham, N. C., 261 W. 34th.
*‡Guernsey, Egbert, 180 South Central Park.
‡Guernsey, Wm. N., 27 W. 52d.
‡Hall, James W., 335 W. 56th.
†‡Hallett, G. D., 132 W. 81st.
*‡Hamlin, F. W., 130 W. 48th.
Hardy, O. S., 251 W. 104th.
‡Harrington, Gove S., 487 West 145th.
Harris, James E., 2000 Lexington.
Harris, Sallie A., 2145 Seventh Avenue.
Harris, James W., 229 E. 124th
Harris, Richard, 2145 Seventh.
†‡Hart, A. H., 130 W. 44th.
*‡Hartley, W. G., 335 W. 34th.
Hasbrouck, Stephen, 68 Broad.
*‡Hathaway, H. S., 146 W. 92d.
*‡Helfrich, C. H., 542 Fifth Ave.
*‡Helmuth, Wm. Tod, 504 Fifth Avenue.
*‡Helmuth, W. T., Jr., 465 Lexington Avenue.
Hills, A. T., 309 Broadway.
Hills, A. K., 669 Fifth.
‡Hinkley, Abbie G., 242 W. 52d.
Hitchcock, Harlyn, 19 Broadway.
Hitchcock, Henry M., 309 Broadway.
‡Hollister, F. K., 59 E. 52nd.
*‡Honan, W. F., Sherman's Sq. Hotel.
‡Howard, C. C., 57 W. 51st.

*‡Howe, J. M., 12 W. 46th.
‡Hoyt, F., 39 W. 58th.
House, W. B., Flower Hospital
*Hrdlička, Aleš, 106 E. 71st.
Hughes, D. Jane, 243 W. 42d.
‡Hull, G. A., 123 W. 73d.
*‡Hunt, D. B., 159 Madison Ave.
††Hutchinson, John, 80 E. 55th.
Husson, John, 305 W. 123d.
Hughes, Harriet, 148 W. 85th.
Humphreys, Fred'k, 22 West 39th.
Irish, James H. E., 63rd and Avenue A.
Irwin, F. C., 657 Park Ave.
Jackson, G. G., Blackwell's Island.
††Jardin, Roland du, 129 E. 76th.
††Jarrett, Elizabeth, 159 W. 48th.
Jennings, Ella A., 28 W. 23rd.
Johnson, P. R., 219 W. 80th.
Jones, Robt. M., 130 W. 48th.
Jones, W. H., 202 W. 74th.
‡Keatinge, Mrs. H. C., 119 W. 48th.
††Keatinge, Harriette d'E., 119 W. 48th.
‡Keep, Mrs. C. J. Y., 308 West 36th.
*‡Kellogg, E. M., (retired), 115 E. 37th.
King, Julius, 2 Maiden Lane.
Kelly, Chas. W., 473 Park Ave.
‡Kidder, Hugh, 305 W. 46th.
*‡King, W. Harvey, 64 W. 51st.
*‡Klots, E. D., 156 W. 48th.
Kolb, Henry, 356 W. 42d.
‡Krause, W. H., 329 E. 14th.
Lacina, A. M., 346 E. 72nd.
*‡Laidlaw, A. H., 137 W. 41st.
*‡Laidlaw, G. F., 58 W. 53rd.
*‡Land, J. F., 130 W. 126th.
Landauer, Simon, 151 E. 54th.
*Langworthy, Anne L., 1381 Boston Avenue.
Laroche, P., 246 W. 31st.
*Lannin, Louise, 148 W. 85th.
*‡Leal, Malcolm, 107 W. 48th.
Lerrigo, P. H. T., Flower Hospital.
Lewis, Henry M., 109 E. 18th.
Lewis, N. H., 224 E. 23d.
Linquist, M. F., 211 W. 21st.
‡Linsley, J. S., 65 W. 70th.
Lozier, A. W., 125th and 7th Avenue.
‡MacBride, N. L., 4 E. 43d.
McIntosh, S. D., 222 W. 43d.
Mac Ivor, Jas. H., 716 E. 138th
*‡Macy, C. S., 117 W. 12th.
*‡Maeder, J. G., 304 East 120th.
Mann, Mrs. M. F., 359 Lexington Avenue.
Martine, Jennie W., 16 W. 61st
Marcy, E. E., 396—5th Ave.
Mayer, Henrietta, 144 E. 89th.
‡McDonald, R. E., 117 W. 44th
*‡McDonald, W. O., 117 W. 44th
*‡McDowell, Chas., 110 W. 12th.
*‡McDowell, Geo. W., 136 W. 130th and 542 Fifth Ave.
*‡McMichael, A. R., 969 Madison Avenue.
*‡McMichael, D. A., 67 W. 96th.
McMichael, J. E., 53 W. 89th.
*‡Meyer, Oscar N., 171 E. 78th.
Miller, J. D., 73 W. 12th.
Miller, C. H., 128 W. 96th.
Miller, C. W., 115 E. 83d.
Miller, Nancy M., 41 W. 26th.
*‡Mills, Walter S., 152 W. 119th.
††Miner, F. C., 1150 Forest Ave.
‡Mitchell, Chas. A., 1812 Lexington Avenue.
Mitchell, L. S., 61 W. 99th.
Morgan, G. E., 2024 Madison Avenue.
††Morgenthaler, Sophia, 131 W. 64th.
Montgomery, R. W., 34 Nassau
*‡Mossman, N. A., 28 E. 47th.
Mount, Margaret A. B., 574 Lexington Avenue.
‡Müller, C. W., 225 East 83d.
††Munson, E. S., 16 W. 45th.
*‡Musits, H. von, 47 E. 83d.
Myers, Chas. F., 261 W. 37th.
*‡Neilson, Howard S., 46 W. 48th
‡Newcomb, Obadiah, 233 East 12th.

*‡Norton, A. B., 16 W. 45th.
*‡Nott, F. J., 554 Madison Ave.
†‡Nutter, Mary E., 144 Lexington Avenue.
Nye, F. A., 2089 Lexington Av
†‡O'Brien, Evelina C. D., 226 E. 87th.
‡O'Connor, Mrs. H. M. C., 29 W. 45th.
*‡O'Connor, J. T., 29 W. 45th.
Ohley, C. H., Metropolitan Hospital.
*‡Ostrom, H. I., 42 W. 48th.
*‡Paige, H. W., 256 W. 57th.
*‡Palmer, A. W., 210 W. 57th.
†‡Palmer, John B., 122 E. 24th.
‡Palmer, Miles W., 235 E. 18th.
‡Pardee, E. B., 218 W. 34th.
Pardee, Walter, 218 W. 34th.
†‡Patchen, G. H., 637 Madison.
Pearsall, S. J., 128 W. 78th.
*‡Pearsall, W. S., 128 W. 78th.
*‡Pease, Chas. G., 101 W. 72d.
*‡Pettet, Isabella M., 308 E. 15th
*‡Pierce, W. Ide, 64 W. 126th.
Piersons, A. M., 24 E. 127th.
Phillips, W. H., Blackwell's Island.
Poindexter, H. M., 36 W. 65th.
*‡Porter, E. H., 181 W. 73d.
‡Powel, Milton, 163 W. 76th.
*‡Queen, L. A., 114 W. 85th.
*‡Rabe, F. E., 227 W. 42d.
Rabe, R. F., 209 W. 56th.
‡Rankin, E. G., 226 W. 59th.
‡Rannefeld, A. H., 85 Seventh.
Reisig, Richard, 438 Central Park, W.
*‡Reynolds, W. U., 320 Manhattan Avenue.
Ricardo, J. N., 228 W. 135th.
*‡Richardson, A. J., 39 E. 83d.
*†Richardson, G. W., 138 E. 79th
Riordan, P. D., 724 Lexington Avenue.
*‡Ritchie, F. G., 131 W. 47th.
Rockwell, Amanda, 213 West 34th.
Robinson, M. M., 1 Madison.
Robinson, E. J. L., 43 W. 50th.
Roberts, Eugene P., 248 West 53d.
*‡Roberts, G. W., 170 Central Pk.
Roder, Elizabeth B., 231 E. 82d
*‡Rounds, W. E., 154 W. 47th.
Royle, Sinclair K., 110 W. 84th
*‡Rudderow, T. D., 328 W. 24th.
*‡Russell, H. E., 30 E. 74th.
*‡Schley, J. Montfort, 628—5th.
‡Schroeder, Marie Ohlmeyer, 925 Jefferson.
*‡Scott, W. H., 104 W. 44th.
‡Sewall, S. G., 71 E. 12th.
†‡Seward, J. Perry, 200 W. 70th.
†‡Sheldon, F. P., 223 W. 122d.
Sheldon, B. B., Flower Hosp.
*‡Shelton, G. G., 521 Madison Avenue.
*‡Shepard, G. A., Broadway and 52d.
*‡Sherman, Irving P., 114 West 44th.
†‡Sherman, L. B., 355 W. 14th.
‡Simmons, R. S., 129 E. 59th.
*‡Simonson, J. T., 46 W. 85th.
*‡Simpson, E. D., 320 W. 115th.
Sinsabaugh, J. A., 672—2d Ave
Slay, J. Clark, 1218 Broadway.
Smith, Caroline M., 240 W. 52d
Smith, G. B., 35 E. 28th.
*‡Smith, Henry M., 228 St. Nicholas Avenue.
Smith, Nelson, Jr., 151 W. 48th
‡Smith, Roswell D., 947 E. 168th.
Smith, Sarah N., 74 W. 35th.
*‡Smith, St. Clair, 25 W. 50th.
*‡Smith, T. F., 264 Lenox Ave.
‡Smyth, S. H., 112 E. 10th.
*‡Stanton, L. M., 132 W. 58th.
*‡Stevens, Anna C. R., 247 West 42d.
*Stevens, D. D., 49—83rd.
†‡Stewart, G. T., Metropolitan Hospital.
Stewart, Ralph A., 63rd and Eastern Boulevard.
Stewart, W. B., 71 E. 87th.
*Stiles, Henry R., 113 William.
*‡Storer, J. H., 30 Edgecombe Avenue.
*Swift, E. P., 170 W. 88th St.

Tantum, P. L., 239 West 21st.
‡Tappen, Ella C. Jones, 346 W. 123d.
*‡Teets, C. E., 37 W. 39th.
Thomas, P. C., 236 W. 55th.
Thompson, A. F., Blackwell's Island.
Thompson, J. C., Jr., 1067 Woodruff Avenue.
‡Thompson, J. H., 36 E. 30th.
*‡Thompson, Virgil, 56 W. 21st.
‡Thomson, J. W., 159 W. 48th.
Tinker, Chas. A., 124 W. 121st.
Tinker, H. H., 1257 Washington Avenue.
††Townsend, Chas. W., 138 West 48th.
*‡Townsend, Irving, 67 W. 46th.
††Townsend, Katherine G., 354 W. 123d.
Townsend, Richard, 24 E. 63rd.
Tuck, A. E., 20 W. 32nd.
*‡Tuttle, E. G., 61 W. 51st.
*‡Tytler, G. E., 113 W. 126th.
*‡Van den Berg, Wm. H., 32 W. 49th.
*‡Vehslage, S. H., 117 W. 43d.
‡Ver Nooy, Chas., 148 W. 64th.
‡Vondergoltz, Eric, 324 E. 15th.
*‡Wait, Phebe J. B., 9th Avenue and 34th.
‡Walker, B. D., 162 E. 122nd.
Walker, L. E., 155 Worth.
Wallin, A. C., 460 W. 145th.
Walter, Josephine, 61 W. 74th.
Welch, F. G., 54 W. 55th.
‡West, Edwin, 155 W. 12th.
*‡Wetmore, J. McE., 43 W. 54th.
Wheeler, John H., 319 W. 54th
*‡White, A. Lenora, 151 W. 46th
‡White, W. H., 56 W. 48th.
‡White, W. Storm, 58 W. 48th.
††Whitehorne, F. N., 64 W. 126th
Whiteman, J. L., 156 W. 45th.
‡Whittemore, Margaret, 32 W. 24th.
Whitmyre, J. P., 63rd and Ave. A.
Wilcox, Emma D., 20 W. 104th
*‡Wilcox, Sidney F., 51 W. 52d.
‡Wilder, L. de V., 55 W. 33d.
Wildes, Thomas, 610 Lexington Avenue.
*‡Williams, T. C., 118 E. 19th.
‡Winterburn, G. W., 46 Bradhurst.
‡Wood, J. Robie, 111 W. 74th.
‡Woodward, A. M., 128 West 113th.
††Worrall, M. Ruth, 239 W. 44th.
††Wright, Amelia, 5 W. 82d.
Wright, P. W., 126 W. 104th.
‡Young, Chas. H., 160 W. 48th.
‡Zeckhansen, Harry, 128 E. 2d.

## NIAGARA COUNTY.

*No Society.*

### GASPORT.

Knapp, F. L. (retired).

### LOCKPORT.

*Blackley, Carl, 247 Washburn.
Buck, Champlin F., 49 Main.
*Hurd, S. W., 78 Main.
Pettit, W. M., 32 Spaulding.
Pettit, Gaylord J., 13 East Avenue.
Rice, Wm. B.
Watters, Fowler A., 29 Main.

### MIDDLEPORT.

Robertson, Mrs. Helen M.

### NIAGARA FALLS.

Gray, John, 1712 Main.
Hodge, John W., 10 Gluck Block.
*Hodge, William H., 8 Gluck Block.
*Hough, Walter D., 635 Main.

### NORTH TONAWANDA.

Bentley, F. W.

**WILSON.**

Draper, Wm. L.

## ONEIDA COUNTY.

*No Society.*

**CLAYVILLE.**

Dewing, W. H.

**BOONEVILLE.**

Babcock, E. C.
‡Warren, W.

**CLINTON.**

‡Dever, I.

**DEANSBORO.**

Fairbank, Stuart J.

**ROME.**

‡Gifford, Alden.
*‡Southwick, A. B.
*‡Scudder, N. C.

**TRENTON.**

‡Spencer, R. S.

**UTICA.**

*‡Capron, C. G., 236 Genesee.
‡Chase, C. E., 230 Genesee.
Cooper, C. G., 8 Carlisle Block.
Fairbank, Stuart J.
Gayde, E. A.
‡Guile, E. B.
*Grant, A. R., 366 Genesee.
*Haines, Charles T., 68 South St.
‡Hennessy, Margaret E., 84 Second.
*‡Laird, F. F., 236 Genesee.
McMaster, Marion.
‡Moore, J. de V., Steuben Park.
*‡Terry, M. O., 196 Genesee.
Warren, Woodward.
*‡Watson, W. H., 270 Genesee.

**WATERVILLE.**

*‡Dean, L. W.

## ONONDAGA COUNTY.

*Annual Meeting, Syracuse, first Tuesday in May. President, W. C. DuBois; Vice-President, C. E. Hinman; Sec. and Treas., A. G. Anthony.*

**BALDWINSVILLE.**

Burch, J. H.
Heaton, Ely.
‡Martin, Alden.
‡Martin, Leslie.

**ELBRIDGE.**

Kaple, Edward B.
‡Warren, Erastus.

**FAYETTEVILLE.**

Badgly, C.
Hutchinson, P.

**JORDAN.**

‡Warren, S. C.

**LYSANDER.**

Doud, F. H.

**LAFAYETTE.**

‡Willer, A. M.

**LIVERPOOL.**

‡Young, J. R.

**MARCELLUS.**

Northway, W. L.

**MEMPHIS.**

‡Sullivan, N. B.

**SKANEATELES.**

*‡Cooper, C. S.

**SPAFFORD.**

Barker, G. E.

**SYRACUSE.**

‡Anthony, A. G., 608 S. Warren.
*Baldwin, G. E., 500 University Avenue.
‡Brewster, A. J., 211 Shonnard.
*‡Candee, J. W., 501 Fayette Pk.
†‡Chaffee, R. W., 1641 West Genesee.
*Church, Herbert A., 601 Warren.
‡Crowell, L. C., 915 E. Fayette.
*‡Du Bois, Willard C., 519 South Salina.
‡Emens, Harriet D., 321 Montgomery.
‡Flint, E. H., 1624 W. Genesee.
*‡Gridley, Geo. L., 1232 South Salina.
Greeley, Geo. H., 510 South Warren.
Guild, L. S. L., 329 James.
‡Hale, C. D., 311 Warren.
*‡Hartman, W. L., 601 Warren.
‡Hinman, C. E., 114 Slocum.
‡Hooker, Frederick, 117 Kirk Block.
*‡Hoyt, Gordon W., 808 Madison
Irons, F. L., 224 Grace.
†‡Keeler, E. E., 452 Salina.
*‡Keese, J. M., 211 Shonnard.
*‡Kinne, A. B., 410 Fayette Pk.
*‡Kinne, E. O., 516 Warren.
†‡Lukens, C. M., 207 East Onondaga.
‡Putnam, F. B., 310 E. Fayette.
‡Schumacher, Carl, 216 Ash.
*‡Sheldon, J. W., 501 Fayette Pk.
*‡Sherwood, B. W., 1117 South Salina.

**TULLY.**

‡Barker, G. E.
*Leonard, Wm. H.

**WARNER'S.**

‡Houston, S. W.

## ONTARIO COUNTY.

*Annual Meeting, Canandaigua, second Wednesday in October. Prest., J. C. Knapp; Vice-Prest., C. A. Rowley; Sec. and Treas., C. T. Mitchel.*

**CANANDAIGUA.**

†‡Mitchel, C. T., 2 Park Pl.
*‡Warner, F. P.

**CLIFTON SPRINGS.**

Boynton, John R.
Conley, L. P.
*‡Foster, Henry.

**EAST BLOOMFIELD.**

*‡Partridge, Barton S.

**GENEVA.**

*‡Covert, N. B.
*Hopkins, W. W.
*‡Knapp, James C.
McKenzie, J. E.
‡Stebbins, J. H.

**NAPLES.**

Conley, D. C.

**OAKS CORNERS.**

*‡Church, G. H., (Lic.)

**PHELPS.**

‡Pritchard, G. C.

**PORT GIBSON.**

*Throop, A. P.

**REEDS CORNERS.**

Marsh, Jas. M.

**SHORTSVILLE.**

‡Cooke, J. D.

**VICTOR.**

*‡Rowley, C. A.

## ORANGE COUNTY.

*No Society.*

**CORNWALL-ON-HUDSON.**

Chandler, David H.

**GOSHEN.**

*McGeoch, R. L.
*Seward, F. W., Jr.
*Seward, F. W.

**MIDDLETOWN.**

*Ashley, Maurice C.
*Barrus, Clara.
Bradner, Julia A.
Emery, Wm. G.
Everett, Edward A.
*Fancher, E., 16 Orchard.
*Francisco, David E.
Hanmer, J. La T., 6 Low Block
*Powelson, Arthur P.
Powelson, Howard J.
Schulz, E. M.
*Talcott, Seldon H.
Turner, Reeve.
*Woodman, R. C.

**NEWBURGH.**

Beattie, Mary E., 118 Grand.
Brink, Wm. H., Grand Ave.
*Jacobson, F. A., 269 Grand.
Manbey, J. A., 233 Liberty.
Mitchell, George B. I., 116 Liberty.
*Mitchell, J. J., 242 Montgomery
Snyder, W. H., 130 Third.

**PORT JERVIS.**

*Best, Fred'k W.
Lambert, E. B.

**WALDEN.**

Faulkner, W. H.
Jaeckel, Chas. E.

**WARWICK.**

Cummins, Frank M.
Cummins, J. Seeley.

**WASHINGTONVILLE.**

Reed, Wm. E.

## ORLEANS COUNTY.

*No Society.*

**ALBION.**

Carrier, E. K.
Hoye, Mrs. S. V.
Norton, F. R.
Stough, C. F.

**CLARENDON.**

Conklin, R. C.

**MEDINA.**

*Gillette, Myra A.,
Scott, F. W.
*Swett, Emily F.

## OSWEGO COUNTY.

*Annual Meeting, Owego, second Tuesday in June. Prest., W. L. Woodbury; Vice-Prest., N. H. Haviland; Necrologist, Sec. and Treas., L. B. Richards.*

**FULTON.**

‡Woodbury, W. L.
*‡Haviland, N. H.

**MEXICO.**

‡Radway, C. W.
‡Stow, T. D.

**OSWEGO.**

*‡Albertson, C. S., 9 W. Bridge.
‡Calisch, A. C., 55 W. Bridge.
*‡Hinman, E. L., 84 W. Oneida.
‡Richards, L. B., E. Bridge and Second.

**PHOENIX.**

Young, Daniel F.

## OTSEGO COUNTY.

*No Society.*

**COOPERSTOWN.**

Blodgett, T. S.
Harrison, H. A.

**HARTWICK.**

Luce, Daniel.

**MORRIS.**

Matison, Merritt.

**ONEONTA.**

*Getman, A. D.

**OTEGO.**

Cossart, James.

**RICHFIELD SPRINGS.**

Getman, Norman.
Ward, Henry A.

**UNADILLA.**

Clark, P. G.

## PUTNAM COUNTY.

(‡*Westchester County Society.*)

**COLD SPRING.**

Winslow, James M.

**BREWSTER.**

*Newman, L. G.
*Brinkman, Mrs. M. A.

**PATTERSON.**

*Birdsall, Thomas P.

## QUEENS COUNTY.

(‡*Kings County Society.*)

**NEW YORK, FLUSHING.**

Allen, Wm. A., Bowne Ave.
Fox, John J.
Gill, J. W.

**NEW YORK, JAMAICA.**

Belden, Chas. K., 28 Clinton Avenue.
*‡MacFarland, R. L., 53 Clinton Avenue.
Noble, Herbert, 49 Union Avenue.

**NEW YORK, LONG ISLAND CITY.**

Brennan, F. E.
Finerty, J. W., 134 Third.
Platt, C. N., 152 Franklin (Astoria).
Strong, C. E., 152 Franklin (Astoria).

## RENSSELAER COUNTY.

(‡*Albany County Society.*)

**CASTLETON.**

Welch, C. D.

**EAGLE BRIDGE.**

Rider, E. H.

**EAST GREENBUSH.**

Curran, S. C.

**GREENBUSH.**

Miller, Horace C., 78 Broadway.

**HOOSICK.**

Donnelly, James H.

**HOOSICK FALLS.**

Hudson, F. R.
Lamb, G. M.
Putnam, W. B.
*Shaw, J. C.

**LANSINGBURGH.**

Holmes, H. P., 512 Second Ave.

**TROY.**

*Benson, R. F., Jr., 2 St. Paul Pl
Belding, R. E., 2141 Fifth Ave.
Bloss, Fred S., 70 Second.
Bloss, Jabez P., 108 Second.
Bloss, Richard D., 1810 Fifth Avenue.
*Coburn, E. S., 91 Fourth.
Crandall, E. L., 1943 Fifth Ave.
Delavan, E. H., 1915 Fifth Ave.
Green, A. R., 25 Second.
‡Griffin, Jennie, Pawling Ave.
*Waldo, H. L., 1834 Fifth Ave.

## RICHMOND COUNTY, (NEW YORK.)

*No Society.*

**NEW BRIGHTON.**

Donovan-Conklin, Fannie C., 48 West.

**TOTTENVILLE.**

Coleman, David.

**WEST NEW BRIGHTON.**

Adams, M. L.
Bryan, William.

## ROCKLAND COUNTY.

**CONGERS.**

La Roche, Pierre.

**NYACK.**

Couch, L. B.
Giles, J. Wm.

## ST. LAWRENCE COUNTY.

(‡*Jefferson County Society.*)

**BRIER HILL.**

Graves, Fred E.

**CANTON.**

Russell, G. A.
*Williams, Frank F., 6 Goodrich

**DE KALB JUNCTION.**

Cole, E. M.

**GOUVERNEUR.**

Flint, W. J.
Haywood, C. W.
*Severance, B. W.

**HEUVELTON.**

Turner, Jason.

**MASSENA.**

Stearns, M. J.

**NORWOOD.**

Sumner, C. Oliver.

**OGDENSBURG.**

*‡Bell, W. N., 6 Greene.
Child, N. N.
Marsh, James M.
*Southwick, D. E.

**POTSDAM.**

Botsford, L. T.
Brown, H. D.

## SARATOGA COUNTY.

*No Society.*

**BALLSTON SPA.**

*Royal, T. Cook.

**GALWAY.**

Ingalls, Gilbert.

**MECHANICSVILLE.**

La Dow, Charles H.

**ROUND LAKE.**

Wilson, Maria L. D.

**SARATOGA SPRINGS.**

Ayers, Mrs.
*Pearsall, John A.
Small, Charles B.
Smith, Melvin D.
Travers, O. J.

**STILLWATER.**

Taylor, George.
Smith, Sarah N.

**WATERFORD.**

Peckham, A. G.

## SCHENECTADY COUNTY.

(‡*Albany County Society.*)

**SCHENECTADY.**

‡Bates, Geo. W., 143 Jay.
*‡Faust, Louis, 19 Jay.
*‡Faust, William P., 29 Jay.
Fiske, Katrina C., 522 Union.
Liddle, Henry S.
Spoor, W. D., 168 Lafayette.
Towne, F. L.

## SCHUYLER COUNTY.

*No Society.*

**MECKLENBURGH.**

Stobbs, A. V.

**WATKINS.**

*Gulick, Wm.
King, Geo. H.

**SLOANSVILLE.**

*Vibbard, Arthur A.

## SENECA COUNTY.

*O. W. Peterson writes: "Society abandoned this day." Feb. 9, 1900.*

**CANOGA.**

Frantz, A. J.

**OVID.**

Horton, A.

**SENECA FALLS.**

*Covert, R. B.
*Follet, W. M., 36 Cayuga.
Weatherlow, Mrs. C. M.

**WATERLOO.**

Drake, M. S.
Peterson, O. W.
Tallmage, A. L.

## STEUBEN COUNTY.

*No Society.*

**BATH.**

Grant, B. F., Advocate Bldg.
Sutton, Orlando.

**CANISTEO.**

Sutton, Frank W.

**CORNING.**

*Bryan, E. W., 23 W. Erie Ave.
Campbell, C. E.
Gamman, C. H.
Gorton, Wm. E.
*Purdy, Mark S., Highland Pines Sanitarium.
*Rodgers, A. H., 50 E. First.

**HAMMONDSPORT.**

Horton, J. T.

**HORNELLSVILLE.**

Coats, Caroline W.
Hathaway, Mrs.
Hathaway, W. E.
Truman, I. P.

**WAYLAND.**

Platt, A. A.

## SUFFOLK COUNTY.

(‡*Kings County Society.*)

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*Woodruff, A. J., 32 Main.

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Ireland, T. L.
‡Manaton, W. P.

**HUNTINGTON.**

*Swords, Geo. P.

**PATCHOGUE.**

*Foster, E. Agate, Ocean Ave.
*Pettit, A. R., Main St.

**RIVERHEAD.**

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Pierson, John G.

**SOUTHOLD.**

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*‡Hyde, L. D.
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*Merriam, H. E.

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Hilton, W. M.

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**FREEVILLE.**

Genung, Homer.

**GROTON.**

Baldwin, A. M.

**ITHACA.**

Beaman, C. P.
Besemer, H. B.
*Besemer, Martin, 40 S. Albany.
*Crum, H. H., 212 Hazen
Eadie, Andrew B.
Griggs, Elma.
Kirkendall, J. S.
Morgan, E. J., Jr.
Nash, E.
Prentiss, Mrs. Adelina E.

**LUDLOWVILLE.**

Fish, Will.

**TRUMANSBURG.**

Terry, David P.

## ULSTER COUNTY.

*No Society.*

**CLINTONDALE.**

Birdsall, W. G.

**ELLENVILLE.**

Harris, Nelson A.
Smith, Henry C.

**KINGSTON.**

Chalker, A. P., (Rondout).
Coles, James C.
Connolly, W. Harry,
*Montanye, W. DeLa (Rondout)
Steele, L. T.

**NEW PALTZ.**

Gerow, Stephen W.

**ROSENDALE.**

Van Demaark, John.

**RONDOUT.**

Skelton, C. W.
Starkey, Daniel T.

**SAUGERTIES.**

Wallace, Wm. I.

## WARREN COUNTY.

*No Society.*

**GLENS FALLS.**

*Birdsall, S. T., 142 Ridge.
*Bullard, D. H., 11 Elm.
Coffin, Henry W.
Horton, C. A.
Little, G. W.
Paine, Howard S.

## WASHINGTON COUNTY.

*No Society.*

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*Clark, L. A.
*Lewis, F. Edward.

**EASTON.**

Mosher, E. E.

**FORT ANN.**

Mott, O. H. (Lic.)

**FORT EDWARD.**

Ball, Russell.
Pattee, Raymond.

**GRANVILLE.**

Mosher, B. D.

**GREENWICH.**

Hulst, Peter H.
Mosher, E. E.

**NORTH GRANVILLE.**

*Spoor, D. E.
Tobey, C. M.

**SALEM.**

Russell, R. G.

**SANDY HILL.**

Infield, Clifford L.
*Van Derweiker, H. W.

**SHUSHAN.**

Leonard, W. A.

**WHITEHALL.**

*Horton, Ernest T.

## WAYNE COUNTY.

*No Society.*

**CLYDE.**

Childs, G. C.
*Hawley, L. B.
Klaer, Clarence.
*Spire, Clayton, E.

**MARION.**

Halsted, Albert R.

**NEWARK.**

Kelly, L. S.
Parson, O. C.
Reed, J. A.
*Thatcher, E. P.

**ONTARIO.**

Peer, Thomas J.

**PALMYRA.**

McPherson, D.

**SAVANNAH.**

*Sweeting, W. H.

**SODUS.**

Hitchcock, C. T.

**SOUTH BUTLER.**

*Sweeting, W. H.
Mount, Garry.

**WALWORTH.**

Rodenberger, E. M.

**WILLIAMSON.**

Austin, A. G.
Clark, Frank Wake.

**WOLCOTT.**

Houston, S. Wilson.

## WESTCHESTER COUNTY.

*Annual Meeting, Yonkers, last Wednesday in January. Pres., N. Nutting; Vice-President, E. V. Brown; Sec. and Treas., H. G. Keith.*

**DOBBS FERRY.**

*‡Hasbrouck, Joseph.

**MAMARONECK.**

Gerard, Louise.
*‡Hall, Matthew J.
Montgomery, R. W.

**MOUNT KISCO.**

*‡Miller, Carlos J.

**MOUNT VERNON.**

‡Ferris, I. W., 149 S. Third Ave.
†Haight, A. M.
†‡Ives, Nathaniel H.
‡Jones, H. C., 220 S. First Ave.
‡Nutting, N., 210 Second Ave.
*Van Denburg, M. W.

**NELSONVILLE.**

‡Winslow, W. J.

**NEW ROCHELLE.**

‡Finch, E. W., Center Ave and Prospect.
Jenkins, Charlotte.
‡Kellogg, Fannie H., 172 Huguenot.
*‡Roberts, D. J.

**NORTH TARRYTOWN.**

*‡Brown, E. V.

**PEEKSKILL.**

†‡Mason, Perley H., 734 South.
*Greene, Chas. R. F.

**PORT CHESTER.**

Clark, Homer.
*White, J. C.
Elmendorf, T. C.

**SHRUB OAK.**

Dresser, G. D.

**SING SING.**

*‡Lane, Irwin J., 2 Church.
*‡Madden, Joel D.
Schafmeister, John A.

**WHITE PLAINS.**

Birch, Chas. E.
*‡Kingsley, O. D.

**NEW YORK, WILLIAMSBRIDGE.**

‡Jones, Hattie.

**YONKERS.**

*‡Fay, R. P., 165 Warburton Ave
Holden, George Parker, 175 Warburton Avenue.
*‡Keith, Horace G., 107 South Broadway.
*‡Phillips, R. O., 275 Warburton Avenue.
‡Stillwell, B. W., (retired).
*‡Trotter, R. R., 189 Warburton Avenue.

## WYOMING COUNTY.

**ARCADE.**

Hulett, Giles S.
Shedd, B. D.

**ATTICA.**

*Gifford, W. B.
Warren, S. G.

**PERRY.**

Hervey, C. R.
Pierce, Mrs.

**PIKE.**

Andrews, L. M.

**WARSAW.**

*Slaught, J. E.

**WYOMING.**

Wadsworth, Robert.

## YATES COUNTY.

*No Society.*

**ITALY HOLLOW.**

Smith, E. D.

**PENN YAN.**

Cox, Joseph T.
Sampson, A. W.
Sampson, F. S.
Tompkins, F.

**DUNDEE.**

Besemer, Arthur.

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